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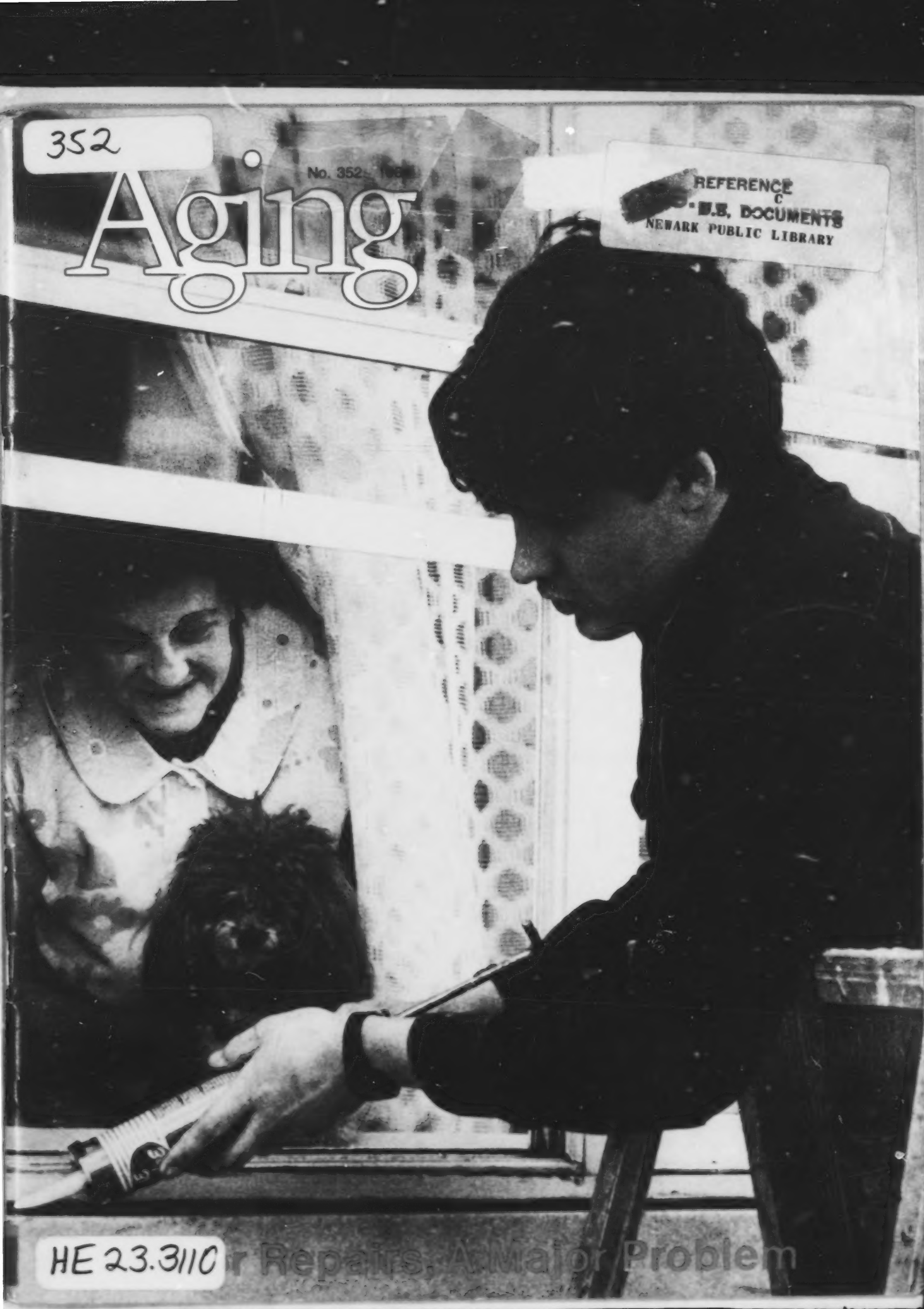

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Repairs: A Major Problem

Commissioner's Corner

Carol Fraser Fisk

In Memory of Dr. Clark Tibbitts

This issue of *Aging* is a very special one, because it is dedicated to the memory of a very special man—Clark Tibbitts. Clark was indisputably one of the pioneering leaders in the field of gerontology. He was also the founder and first editor of this magazine. Clark passed away on October 11, but he remains with us in the institutions and programs which he helped to create, in the books and articles which he wrote, and in the vastly increased national interest in the welfare of the elderly which he helped to stimulate.

Before joining the Federal service in 1949, Clark had been with the University of Michigan for 12 years where he had been a major figure in the development of the Institute of Gerontology. While at the University, he also carried out one of the first empirical studies of aging in America.

Upon joining the U.S. Federal Security Agency, Clark helped to design and carry out the first national conference on aging in 1950 which produced the report, "Man and His Years." Following the conference, Dr. Tibbitts became Chairman of the Federal Security Agency's Committee on Aging, and when this agency was expanded into the U.S. Department of Health, Education and Welfare in 1953, he became a key staff member for the Special Staff on Aging in the Office of the Secretary. In 1962 the Special Staff was merged with the newly created Office on Aging, the predecessor to the Administration on Aging which was established in 1965.

During these years, Clark developed a study-discussion program for the Fund for Adult Education; authored *Aging in the Modern World;* edited the first edition of the *Handbook of Social Gerontology,* which for a decade was the principal textbook on aging; and organized a series of Federal-State conferences to encourage the creation of State Agencies on Aging.

He was also the first editor of *Aging* magazine; a core member of the Interuniversity Council on Social Gerontology, which conducted orientation sessions on aging for some 75 representatives of organizations and colleges; and organized and provided leadership to the International Association of Gerontology. As if these demanding tasks were not enough, Clark also found the time and energy to develop the format for the 1961 White House Conference on Aging.

In 1965, Dr. Tibbitts became Director of AoA's first Training Program, which helped to establish gerontology programs at colleges and universities across the nation. Clark was also one of the two Technical Directors for the 1971 White House Conference on Aging. In that capacity he helped to set up community forums in over 5,000 locations so that the Conference participants could learn first hand the concerns and problems of older Americans.

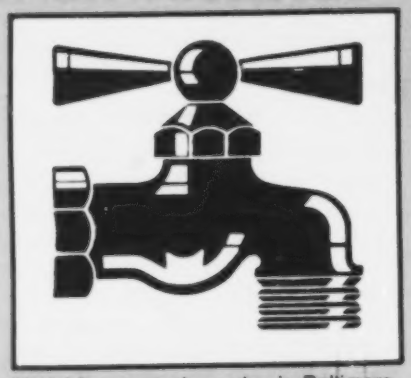
From 1973 to 1976, Dr. Tibbitts created and directed the National Clearinghouse on Aging in AoA. I served in an Area Agency during this period and remember how very responsive and helpful Clark and his staff were to us. Clark concluded his years of Federal service on the immediate staff of the Commissioner on Aging. He participated in planning for the 1982 World Assembly on Aging and prepared three chapters in the U.S. Report to the Assembly. He also authored a major paper on the history of training programs and narrated a series of training films on aging policy.

When he died at age 83, Clark was devoting his formidable energies to yet another career and goal—the creation of a retirement community in Ann Arbor for alumni of the University of Michigan to be built on land owned by the Tibbitts family.

Clark has now passed the torch to the many people that he knew and influenced in the field of aging. His work and his dedication helped expand the cadre of well-trained personnel who now help so many older Americans to maintain their independence. Because of him, the field of aging is enhanced by new knowledge, new programs, and new ideas. Clark will be missed, not only as a friend and valued colleague, but because few can hold a torch so high.

Aging

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration on Aging



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Minor Repairs, A Major Problem For Older Homeowners

Low-cost home repair service aids four Baltimore neighborhoods

by Kimberley McCleary

What do you do if you're in your 60's or 70's, live alone and don't have the strength or the skills to make minor repairs on your home? Older people often find themselves in this situation, and for some, friends and relatives provide the needed help

But a widow living in Maryland whose two sons have moved to California may have no one to call when her roof begins to leak. Even though contractors provide valuable services, many are in business primarily to complete major repairs and renovations. Most simply will not accept small jobs. Those who are willing to take on jobs such as minor toilet repairs and paint touch-ups feel they must charge their standard hourly rates so as not to lose profitable work time. Thus, older customers may spend hundreds of dollars yearly on repairs they once did for themselves. Some seniors become frustrated and allow their homes to deteriorate. Others give up lifelong residences and move to apartments.

These unhappy alternatives can be avoided, however, as one Baltimore organization has shown, if communities are willing to take the time to organize a home maintenance program to help out the elderly. Banner Neighborhoods Community Corporation (BNCC) is a non-profit organization involved in various projects to assist residents of four predominantly working class neighborhoods—Baltimore-Linwood, Butchers Hill, McElderry Park and Patterson Place.

Funded by a combination of public and private sources, including Community Development Block Grants, the Macht Foundation, the Baltimore Oriole's Foundation and Hechinger's home-improvement stores, Banner Neighborhoods is committed to assuring stability and growth in the four neighborhoods it serves. It acts as an umbrella organization for the neighborhood associations and groups in each of these areas in helping them to address common problems, ranging from trash in the streets and housing code enforcement to crime prevention and summer youth employment.

BNCC's strongest and most successful venture, however, is its Home Maintenance Service. The program's goal is to provide home repair service to area homeowners who are at least 60 years of age (at least 55, if they are disabled) and whose income will not permit the expense of contractors. Eligibility is currently limited to elderly persons with incomes under $8,000.

Started in 1978 with support from The Ford Foundation, the Home Maintenance Service soon became a

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Kimberley McCleary is a freelance writer and photographer pursuing a degree in English at the College of Notre Dame of Maryland. Ms. McCleary spent the summer of 1985 observing and working with the staff and clients of Banner Neighborhoods Community Corporation.

demonstration project of the U.S. Department of Housing and Urban Development. After the demonstration ended, the Banner Neighborhoods Community Corporation assumed responsibility for the program in 1983.

Repairs In 200 Homes

Today, the Home Maintenance Service enrolls 200 elderly homeowners, whose requests for repair services are handled by an amazingly small crew—a supervisor in his 50's and a 21-year-old worker. Last summer, they were assisted by four teenagers hired as house painters through Baltimore's youth employment program, and another teenage worker hired with BNCC funds.

"We may be small, but the service handled about 1,000 repair jobs last year," notes Mrs. Neetu Dhawan-Gray, Executive Director of BNCC.

Explaining how such a small crew can handle repairs in 200 homes, she points out that a good number of the homeowners have been enrolled in the program for three or four years. "For them, the initial labor-intensive home repairs, involving costly materials, have been completed and we are now engaged more in preventive home repair. Continued enrollment for these homeowners is a kind of insurance that they will have access to our services when and if they need them."

The Executive Director stresses that costs in time and materials for the client and for the program really go down the longer they are enrolled in the service. "It's the first-time enrollees that cost the most."

Clients pay an annual fee of $25 which entitles them to $50 worth of home improvement materials made available through the program. After the first $50, clients pay for their own materials at cost. Once a client is enrolled, his or her home is surveyed, and needed repairs are made. Any time during the 1-year period covered by the basic fee, clients may make up to three "call-backs," requests for additional repair work. Repairs covered by the program include the following:

Safety

- Repair of unsafe floors and stairs
- Repair and/or installation of railings
- Patching of mice and rat holes
- Installation of grab bars and smoke detectors

Security

- Installation of deadbolt locks on exterior doors, peep holes on entry doors, window bars, and sash locks on windows.
- Adjustment of doors

Energy

- Weatherstripping and caulking of windows and doors
- Repair of broken windows, storm windows and screens
- Installation of plastic on windows
- Change of furnace filters

Exterior Maintenance

- Painting: cornices, window trim, doors, steps, wooden gates, shed doors
- Minor roof repairs
- Grouting of steps
- Cement patching in yard
- Replacement of exterior door
- Rebuilding of wooden gate and wooden steps
- Repair or installation of railings
- Repair of gutter and downspouts

Interior Maintenance

- Plumbing: cleaning clogged drains, repair of leaking faucets, repair of over-flowing and non-flushing toilets, installation of new faucets
- Electrical: repair of faulty switches, receptacles, and fixtures, and repair of doorbells

The program is not equipped to do major improvements or renovations but will provide referrals to contractors or other housing repair resources in the city. Since BNCC is dependent on public and private funding of approximately $65,000 each year for the Home Maintenance Service, enrollment must be limited. However, to the 200 elderly East Baltimoreans participating in the program, its services are indispensable.

A Proud, Ethnic Neighborhood

East Baltimore is best known for its "neighborhood life" and its strong sense of community. From the neatly-lined row houses of Baltimore-Linwood to the turn-of-the-century homes of McElderry Park, Baltimore's eastern section is an area of working class people struggling to preserve ethnic pride and neighborhood unity in an age of increasing depersonalization.

The religious, racial, and ethnic mix is quite varied, with the predominant nationalities being German, Irish, Italian, Polish and Ukranian. Some residents are immigrants, but many are first- or second-generation Americans who grew up hearing the immigration stories of their parents and grandparents.

"When the potato famine struck Ireland," explains lifetime resident Kathryn Burke, "our people came to this area looking for work." Most East Baltimoreans can make similar statements; either they or their families emigrated to escape hardship and find opportunity. The steel industry, a local meat-packing plant and numerous small, privately-owned shops provided work when they came to this country, and the small, newly developed row homes offered affordable housing.

Bob Orem, President of the Baltimore-Linwood Association, estimates that even today, 75% of his community's homes are owner-occupied.

"I've lived in this house all my life," says Frances Mary Adams of Patterson Place. "I was born right

Mrs. Dausch is happy to see her door fixed by John Wilson from Banner Neighborhoods.

here. I'm 76, and I'm not about to leave now." After her mother's death, Mrs. Adams and her husband bought and renovated the house. Now a widow, she depends on the Home Maintenance Service for the upkeep of her home. "They've done so many things I could never do myself," says Mrs. Adams.

Dot Rupp of Baltimore-Linwood agrees. "The program is wonderful," she says. "The men are always pleasant and helpful. I'm proud of my home. The program takes care of all the little jobs that keep it nice."

Keeping their homes and neighborhood clean and attractive is important to longtime East Baltimoreans. Nina DeSimone, president of Community Taking Action (CTA), Patterson Place's neighborhood organization, stresses the importance of community cooperation. She believes that the key to a successful neighborhood is "getting as many people involved as possible."

Bob Orem agrees. He describes his neighborhood briefly and emphatically. "Fan-tastic! There's no place like it." Although Orem leads his neighborhood organization, he personally attends to many of the smaller yet essential tasks such as surveying local streets and alleys for sanitation and exterior home maintenance problems. For the staff and friends of BNCC, "community service" is far more than an organizational description. It is a way of life.

Jackie Hernandez works as the corporation's maintenance counselor. "I don't mind the paperwork," Jackie explains, "but it's the people I love. I really enjoy working with the senior citizens. They have so much to say, so many memories." Ms. Hernandez and her family live just a few blocks from the BNCC offices, and the program's enrollees are her friends and neighbors. As maintenance counselor, she visits them in their homes, explains the program to them and shares a little of their lives.

"When we first started in 1983," Director Neetu Dhawan-Gray says with a smile, "we had to prove ourselves. This neighborhood is like a big family. Outsiders are not immediately welcome." Working with an entire community of strong-spirited working class people, she believes, requires a deep intangible knowledge of their life style, beliefs, dreams and conflicts. She also believes that hiring members of the community can mobilize natural neighborhood strengths and increase the sense of commitment among the residents."The workmen *want* to do a good job because they are working for friends and neighbors—their own people."

"Most of the work crew are young men," says client Grace Potts, "and a lot of young people nowadays are irresponsible. These boys are different. When they say they're going to do something, they do it!" Like other BNCC clients, Mrs. Potts has trust in the program's staff.

Neetu Dhawan-Gray believes it's Banner Neighborhoods' "us helping us" philosophy that builds the trust. "I know most of these people and how to work with them," Ms. Dhawan-Gray tells a visitor in between phone conversations. Much of her time is spent in phone negotiations. BNCC works hard to maintain excellent relations with its board of directors whose members are drawn almost entirely from the community and local businesses. The board understands the pride East Baltimoreans have in their heritage, their surroundings and most of all, their homes.

"This place might not be fabulous, but it's my home, and I love it. I don't know how I'd manage its upkeep without help." Frances Adams raises her voice a little whenever she talks about Banner Neighborhoods.

"God bless that Maintenance Service!"

Governor Adds Repair Services to 1986 Housing Initiative

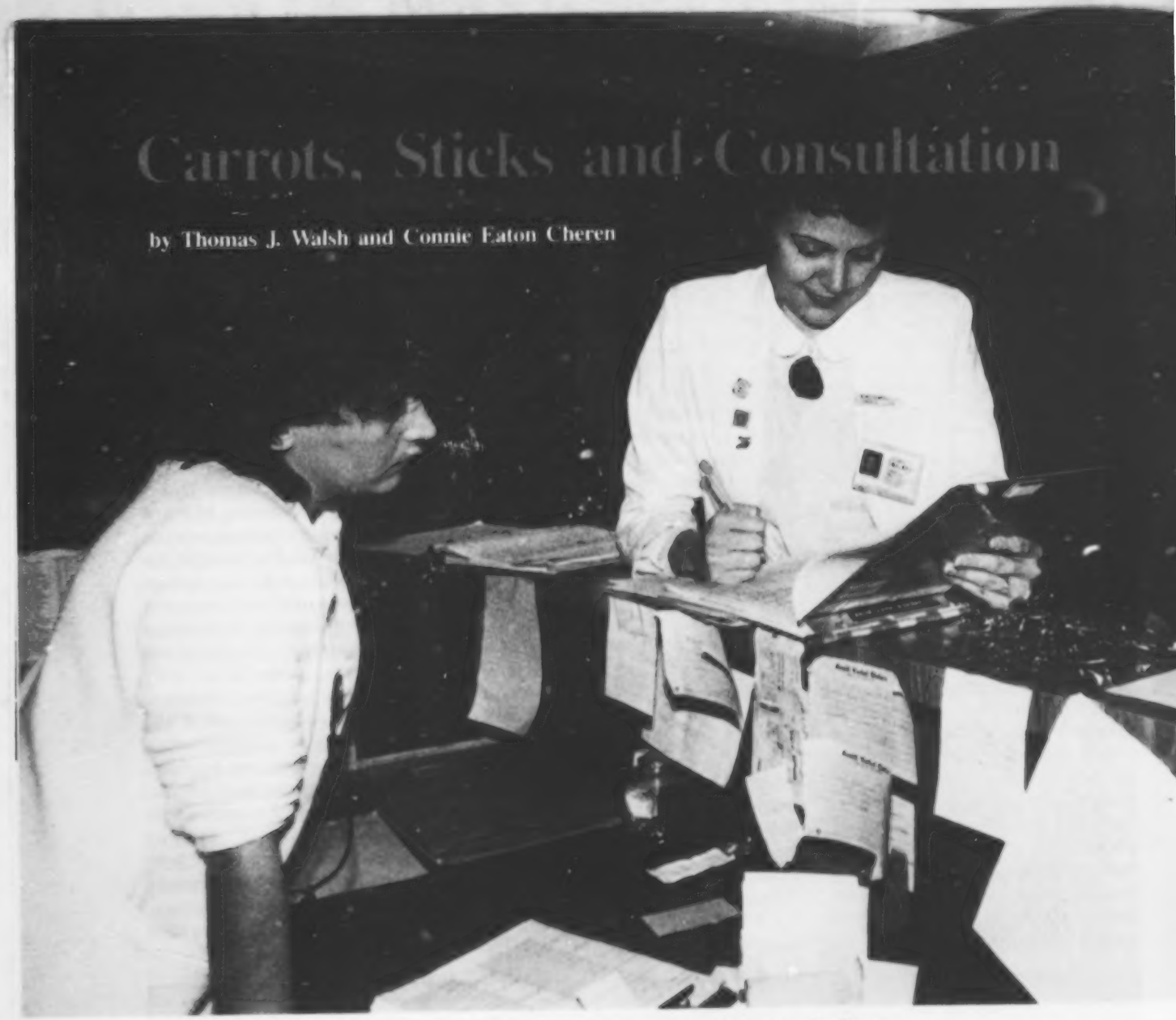
Since this article was written for *Aging*, Banner Neighborhoods has been involved in an exciting development that may mean creation of home repair services for the elderly throughout the State of Maryland. Governor Hughes has approved and incorporated into his 1986 housing initiative a proposal to fund nonprofit organizations across the state to develop home repair services modeled on the Banner Neighborhoods program. If the Legislature approves the proposal, BNCC would provide technical assistance to these groups.

Banner Neighborhoods was also recently awarded a $10,000 grant by United Way to receive referrals from the Visiting Nurses Association (VNA) and Francis Scott Key Hospital to do "accessibility repairs" in the homes of the frail and disabled elderly—widening of doorways to accommodate wheelchairs, relocation of plugs and switches, addition of grab bars, and installation of special doorknobs and fixtures for the arthritic. The State Vocational Rehabilitation agency has agreed to train the Banner Neighborhoods staff in making these adaptations.

"We, in turn, will be referring clients who need home health services to the VNA and Key Hospital," says Banner Neighborhood's Executive Director Neetu Dhawan-Gray. "It's really crucial for health organizations and grassroots groups like ours to begin talking to one another about meeting the needs of the frail elderly. It's this kind of coalition building that will be the wave of the future in finding solutions to the multiple problems of elderly people who want to live out their lives in their own homes."

Carrots, Sticks and Consultation

by Thomas J. Walsh and Connie Eaton Cheren



Betsy Tannahil, Health Facility Surveillance Nurse, goes over patient records in a nursing home.

Illinois recently established a new program to improve the quality of nursing home care throughout the state, a program that relies heavily on consultation and dissemination of best practices to long-term care staff.

This new consultative approach was adopted because state officials began to question some of the assumptions underlying the traditional method of regulation—periodic inspections. In homes owned or operated by medically trained personnel, with broad access to medical expertise, with skilled staff and regular visits by patients' physicians, periodic inspections might realistically be relied upon to pinpoint problems in the quality of care.

But the officials knew that these optimal conditions certainly did not apply in all nursing homes. Some are owned by real estate investors, others benefit from little oversight by patients' physicians, and many depend on semi-skilled nurses aides who are paid relatively low wages. Especially in these homes, training and consultation seemed to offer a much better solution than brief inspections to reveal problems that the staff might not have the knowledge or the organizational skill to correct.

When Illinois Department of Public Aid Director Gregory L. Coler announced the new effort, he stated: "Illinois residents of long-term care facilities deserve the best possible nursing home care, and Illinois tax-

Thomas J. Walsh is the Medical Assistance Programs Administrator for the Illinois Department of Public Aid and Connie Eaton Cheren is Chief of the Department's Bureau of Long Term Care.

payers have the right to demand that such care be cost-effective. Through this new program, we are determined to provide all nursing homes throughout the state with the incentive and the means to achieve a higher quality of care."

Mr. Coler's statement pointed to the other key ingredient in Illinois' new program—incentives that would tie the level of Medicaid funding going to a nursing home directly to the quality of care.

The Illinois Approach

The State began with the assertion that long-term care residents deserve the representation of a case manager. The manager is not an ombudsman with thousands of constituents and little authority, but an advocate who is specifically assigned to a set of residents and given the responsibility and authority to assure adequate care. This case management concept has been applied in other areas, such as child welfare and mental health services, and even to Health Maintenance Organizations (HMO's). Given the dependency of long-term care residents and, in many cases, the absence of nearby family members to protect the patient's interests, case management makes eminent sense.

The Illinois Department of Public Aid hired 130 nurses to act as case managers for approximately 55,000 residents who receive funding through Medicaid. All these staff are RN's with a minimum of three years professional nursing experience. In fact, the experience of staff generally exceeds three years and often reflects a broad background of employment in hospitals, in nursing homes, and as nurse practitioners.

On average, each nurse manages care for 480 patients and is assigned to from 2 to 14 facilities. While this may seem like a large caseload, once the case manager has identified problems in delivery of care to 15, 20, or 30 patients, the improvements suggested may have an impact on 150 residents. The goal is change within the overall system of care in the facility.

Rather than taking a regulatory approach to case management, Illinois Department of Public Aid nursing staff have been trained to take a consultative approach to assuring quality care. Individual owners and operators sometimes have a limited perspective on effective nursing or management options, and the case manager can refer to experience and innovative solutions at a variety of homes.

In addition, the nurses quickly found out that inadequate care is not always recognized by either ownership or management. In such cases, penalties, alone, will not be effective, because the problem is not understood, much less the solution. Rather than threaten immediate penalties, closure, or transfer of patients, all of which have potentially traumatic side effects, the first role of the case manager is to advise the facility of perceived problems and to suggest improvements in care.

DPA Nurses Control Funding

While consultation can be a helpful general approach to improving care, consultation, alone, may not suffice in all cases. Consequently, the State placed two major tools at the disposal of the case manager which provide significant financial incentives for improved care—the Inspection of Care process (IOC) and the Quality Incentive Program (QUIP).

In Illinois, the IOC process not only fulfills the federal inspection requirement, but also serves as a basis for rate setting. Long-term care re-

Betsy Tannahil hears first-hand from a nursing home resident about the quality of care.

imbursement is based on assignment of points indicating the number and type of care needs experienced by patients. For example, a patient who needs assistance in bathing, feeding, and dressing is assigned more points, and therefore qualifies for higher Medicaid reimbursement, than a patient who needs help only in dressing.

But does assistance in bathing mean help getting in and out of the bathtub or a nurse's aide to wash the patient, and does assistance in feeding mean help opening a milk carton or actually being fed by an aide? In the past, the basis on which points were assigned to patients frequently varied from facility to facility. Under the new Inspection of Care process, more uniform criteria for assigning points to patients have been established. The precise needs of all patients are assessed twice annually, and this data is then used to set the facility rate.

Also scored at the time of the Inspection of Care is the case manager's assessment as to whether the identified needs of the patient were adequately met by the facility. In the future, those needs that are not adequately met will not be allowed to serve as a basis for setting the level of reimbursement.

Thus, the case manager has a very powerful and precise tool for focusing attention on provision of appropriate medical services. When the case manager suggests an improvement in care, facility staff understand that the same nurse will be scoring the Inspection of Care review, marking needs not met and reducing reimbursement if an important suggestion is ignored.

A second major tool at the disposal of the case manager is a new component of the reimbursement system that adds a premium to reimbursement for services above minimum quality. This Quality Incentive Program, or QUIP incentive, is based on an evaluation of quality provided in five areas found on the QUIP "report card":

- *Environment*. Is the physical environment clean, personalized and homelike?
- *Participation*. Are residents engaged in meaningful activities tailored to their needs and likes?
- *Community Integration*. Do residents have at least two hours per week of active involvement in the community—going to church, visiting a museum or participating in a community-sponsored event? The community involvement should be consistent with the patient's interests and role prior to entering long-term care.
- *Resident Satisfaction*. Do residents feel the facility meets their needs?
- *Patient Care*. Are residents assessed and appropriate goals established. Do the residents meet these goals? Additionally, the facility may develop four intensive nursing programs to address problems of their residents, such as restorative nursing, discharge planning or a special program for Alzheimer's patients.

Depending upon how the case manager scores the facility during his or her assessment, the facility can receive additional reimbursement of up to $2.00 per resident per day. For a 200-bed facility, this can amount to over $140,000 per year in addition to the normal cost-related reimbursement. Thus, QUIP provides a financial incentive for the facility to provide excellent care.

The QUIP program has focused on encouraging effective assessment of patient needs and care planning. The care plan serves as a basis for evaluating whether activities are appropriate for the resident, which care goals are important, and which intensive services are appropriate for the facility.

Department of Public Aid nurses are helping facilities to establish more precise patient goals by breaking them down into concrete tasks. They are not content with a general goal such as "The patient will be able to feed herself." The nurses will specify, "The patient will learn to grasp a spoon."

According to one department official, "only a very small number of homes in the state had measurable goals for patients before the new system was introduced. In fact, the nursing home staffs often assumed progressive deterioration in patients—so there were no goals that really envisioned improvement."

The combination of tools provided by the Inspection of Care and the Quality Incentive Program place the case management nurse in a particularly strong position to influence care in facilities. Each nurse has a role in advising the facility regarding patient assessment and care planning, and evaluates the appropriateness of care plans. Then, the nurse monitors the provision of care to ensure that the care plan is carried out. At two points during the year, each nurse conducts a formal assessment of care to determine whether the needs of each public aid patient are being adequately met and whether care is sufficiently above minimum quality to qualify for a bonus payment.

In assuring the quality of care, the case management nurse has a variety of options available. The nurse can work directly with the Director of Nursing and nursing staff to bring about suggested improvements, or approach the administrator or owners. In either case, the nurse's judgments and direction will affect facility reimbursement. The case manager is placed directly in charge of the funding flow, so that when the facility is providing services and intervention for the patient, the funding follows. This is a much more finely tuned system for achieving quality control than financial penalties, decertification, or delicensure, alone, and can be directed at specific patients and their needs.

One official familiar with the old and new system commented: "Previously, there was a real void out there—no state of the art or dis-

semination of the best practices. Publicity has always focused on the bad homes, so the mediocre providers were saying, 'We're doing really great if you compare us with those substandard homes.' Now we're telling them we want them to compare themselves with the *best* nursing homes in the state. There's more than money involved—pride in the facility is beginning to come into play."

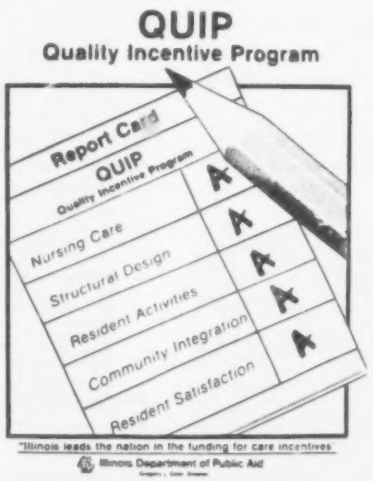
Targeted Inspections

While the case management system calls for biweekly visits to each facility, in some cases, a simple periodic presence in the facility has proven to be insufficient. In a number of homes, the nurse case manager believed that nursing care was problematic, but lacked hard evidence to substantiate that suspicion. The case manager's inspection necessarily relied to some extent on nursing records, and, in some cases, the charting was too vague to confirm improper care. In others, the case manager felt that charts reflected what should be happening rather than actual care provided.

To address this barrier, the Department of Public Aid developed what is called the "Targeted Inspection of Care Approach." It differs from standard procedures in several ways. First, a team of nurses is deployed to examine a facility. Second, each member of the team identifies a group of residents, examines their records, and carefully observes the care they receive throughout an 8- to 10-hour period. The team documents the care actually given by the facility.

If, when the targeted inspection is complete, there appear to be deficiencies in the care provided, a meeting is scheduled with the owners and key facility staff. At this meeting, accumulated documentation is presented to indicate exactly where care was deficient, and the implications of failure to correct the situation are described. If problems are severe, failure to correct them can lead to decertification, freezing admissions, or loss of license. The Illinois Department of Public Health, which licenses facilities, is notified of the findings.

To date, of 23 facilities targeted for more intense inspection, 21 have been found to have important deficiencies in the nursing care provided, and two have been found to have no significant problems. In every case where problems were identified, the facility management has chosen to work with the Department of Public Aid nurse to remedy the problems. The case management nurse and the supervisor, then, take on an assertive but helpful consultative role in assisting the home.



In virtually all cases, facilities have made rapid initial progress in correcting obvious deficiencies, such as improving cleanliness or the appearance of the home. More difficult, however, is correction of the underlying causes of care inadequacies, such as staff disorganization, lack of appropriate care planning, etc. Only about half of the targeted homes have been able to address these more fundamental difficulties. But these homes are now very much aware of their problems and know that help is available from case managers in devising solutions.

In too many instances in the past, substandard care was simply not recognized by managers, and when it was pointed out by regulators, was dismissed as transitory or inconsequential. This suggests, again, that a traditional approach of penalties, alone, without consultation and cooperative effort, will not improve care. The detailed documentation developed during the new Targeted Inspection of Care procedure has been essential in convincing a facility that inappropriate care exists. Once convinced, they have responded with investments and concerted efforts to correct the problems.

Prognosis for the Program

Initial acceptance of the Department of Public Aid program by the long-term care industry in Illinois has been good. There have been some objections to the speed at which the new programs have been introduced, to the changes from past administration of the program, and some allegations that staff have applied standards differentially.

The behavioral response of the industry has, however, vastly overshadowed objections. The case managers have been accepted by long-term care operators and staff as an important link between the Department of Public Aid and facilities. In fact, a common complaint during the start-up phase of the program has been that the case managers have not been in their facilities as often or as long as expected.

The QUIP Program, which was voluntary, achieved a participation rate of better than 90% of eligible facilities. Perhaps most important, the industry has begun to accept the Department's emphasis on care planning and management for long-term care residents. Care planning seminars have been presented throughout the state by the Department, with sponsorship of most of the state's long-term care associations.

Although it is still too early to determine the full impact that care plans, evaluations and cash incentives will have on the quality of care delivered, the early indications are that it will improve the lives of nursing home residents substantially.

Age Barriers Fall

A high school creative writing class for two kinds of seniors.

by Jean B. Rose

"I enjoy looking into their faces and sharing some of their feelings," explains 70-year-old Janet Shook, referring to her teenage classmates.

"At first you feel uncomfortable, but after a while, the person becomes an equal part of the group," says 12th-grader Paul Nelson of his fellow adult classmate.

Mrs. Shook and Paul Nelson both attend a creative writing course that I teach at Scotia-Glenville High School in upstate New York, an area that includes both suburbs and rural countryside. The class is a 12th grade English elective which develops creative writing skills while integrating two age groups who normally have little contact.

Today's soaring divorce rate, the decline of the extended family and the growing popularity of retirement communities all contribute to the distance between young and old. Concerns once shared under a common roof now divide communities. Younger voters resent Social Security payments, and older voters reject school budgets. With respect to certain social, political and economic currents, the generation gap seems ever widening. But the natural affection and ability of the two age groups to communicate emerges quickly when they are brought together for a common purpose or task.

Several years ago I was teaching creative writing at a local Senior Citizen Center, with help from a high school student who served as my assistant. In every class, I was struck by the excellent rapport that the student had established with the senior citizens. I thought, "Why should my classes be segregated by age," and decided to invite my class at the Center to the high school. They accepted and thus was the beginning of several highly successful interage programs sponsored by our school.

The "Community Creative Writing Class" fosters the sharing of feelings and experiences. The common problems involved in learning to express oneself in writing create a marvelous atmosphere of cooperation. Age barriers fall, and first name friendships develop. Younger students often volunteer to drop off papers at the homes of older class members. The class benefits the entire high school, for our students are now accustomed to an elderly lady or gentleman weaving through a crowded hall, notebook in hand, immersed in a conversation with a young person or responding with a smile and a wave to the yell, "Hey, Margaret! How are ya?"

Older adults attend the lecture session which introduces the assignment that they are to complete at home. At the end of the week, they return to participate in the writing session where groups of four discuss each other's work, sharing common problems, complimenting good passages and suggesting improvements. Group membership remains consistent throughout the course, and adults and teenagers become appreciative friends.

As I frequently tell my students, "Everyone can succeed at creative writing." I am careful to make the assignments, which generally draw on life experiences, apply to people at all stages of life. One popular assignment encourages self-discovery, analyzing and revealing some interesting or puzzling part of yourself. For Mrs. Shook, this assignment led to an intriguing poem on the ambiguity of personality.

Josephine Nolan (center) gets helpful comments on her latest short story from (left to right) Jackie Dunbar, Steve Parrow and Lyn Hollenbeck.

Jean B. Rose teaches English at Scotia-Glenville High School in Scotia, New York.

Al Pirro (center) reviews John Borst's essay with help from Mindy Van Valkenberg.

Who Am I

Born under the Libra sign,
Of equally balanced scales.

Named for the two-faced Janus,
Looking backward and forward at once.

The only child of immigrants
From sunny Italy and chilly Scotland.

Opposites in one person
On a tightrope of equilibrium.

A brain cluttered with trivia
Lit like a pinball properly played.

Crowds repel me; individuals fascinate.
I am a secret watcher of mankind.

My outer self is aged and hampered.
Inside I am as young as always.

My best friends are my family,
My worst enemy is myself, talking.

My complexity can be replaced
But never duplicated.

Janet Shook

Another very successful assignment followed our class visit to "A Vanished World," an exhibit of photographs of Jews in Poland just prior to World War II. This visit prompted lively, sometimes heated discussions of war and its consequences. The exhibit also stirred some powerful reactions in the adult members of the class. In a haunting poem, Sonja Klinkow, age 64, imagines the circumstances surrounding the photographing of a Jewish village elder in Poland in 1938:

Elder Of The Village

Flowing black robe beneath tall black hat,
Cold sunlight halos the white beard, highlighting
Tendrils of curling hair.

Artistic long fingers, surprisingly young
For an old man.
One hand supports his body on the cane,
The other semi-shields his face.
As the Nazi officer brazenly focuses
His tiny black box,
The elder stares into nothingness
Through large, protruding eyes
Filled with horror of the torture
  That has been
And sense of the holocaust
  That is to come.
Complete despair as the camera clicks.
To document forever
The sorrow of the living dead.

Sonja Klinkow

The younger students were also eager to hear from the men who had actually experienced wartime, although 61-year-old Al Pirro's account of going off to Africa at age 19 may not have been quite what the students imagined from reading history books.

"Our high school students are used to an elderly lady or gentleman weaving through a crowded hall, immersed in a conversation with a young person."

The Beginning

World War II—at nineteen
Quartered on a Liberty boat
Steaming out of Newport News,
Destination—unknown.

A convoy stretching from one horizon to another
The ever-present dread—German U-boats
Lurking in the sinister sea.

Paramount in our anxiety—
Where in hell were we headed?
Rumors flew—Africa!
The dark continent—hot, tropical forests
Dry, barren deserts.
At last the speaker boomed,
Oran, North Africa!
Disembarking, seeking jungles and natives,
Amazed there were none!

Whisked to a mountain camp via armored vehicles
Set up tents!
A cold, chilly night and next morning,
Snow on our tents!
Atlas Mountains clothed in sparkling white splendor
It was COLD!
And this was AFRICA!!

Al Pirro

Assignments stress the basic elements of good writing. The class learns, for example, that it's often more effective to depict personality through speech and actions than it is to describe it. Sometimes a few simple quotes can leave a vivid impression, as this piece by Margaret Powers, age 60, indicates:

Monologue

"Come in, beautiful! You are the essence of loveliness! Haven't seen anything as well made since last time you visited . . even washed the shoe strings in your sneakers!

Join me in a cup of coffee. I just happened to 'womp up' some venison and scrambled duck eggs. . a discriminating nutriment if I must say so myself! These edibles will put blisters on your innards!

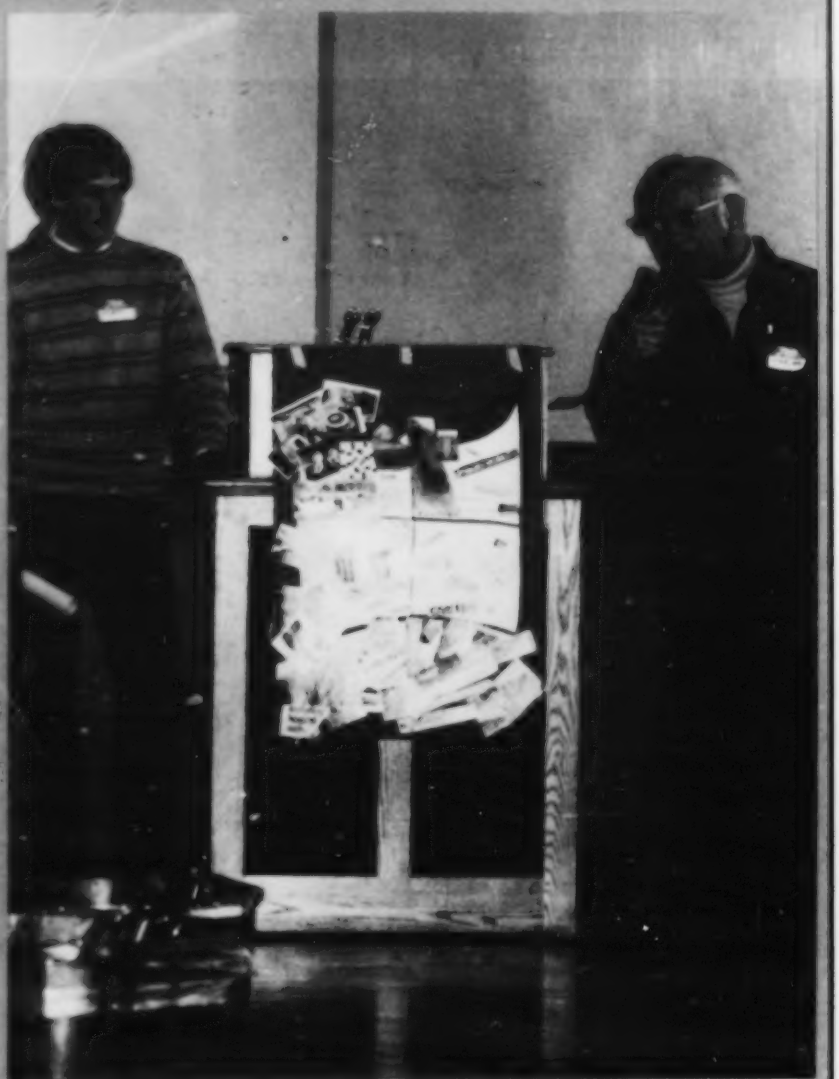
Don't be harassed by my cats! A mixture of sweet corn and dry elements magnetizes their perceptive paunch. Just move your plate a notch to the right, and perchance they will heed the intent. They shouldn't be around too long . . . woke me up before dawn to exhibit the catch of the night. . .

How goes it with your garden? Anything you need? I am wearying of the chores and obligations. The racoon without a tail passed by the other evening—looking for leftovers—a sure sign of what's to come. . ."

Margaret Powers

Allowing adults to attend daytime classes isn't a new idea, but we have learned first-hand that it's a very beneficial one. Older adults bring experience and a different perspective into the classroom. They teach and learn from their teenage classmates. Outlooks change as people at two different stages of life share and discover common fears and concerns. In a society where the senior citizen population increases by 1,600 individuals each day, such lines of communication are imperative.

Scotia's Interage Seminar



A senior citizen and a high school student explain the "Coat of Arms" their group created on values, pleasures and the world's greatest problems. Above left is another group's "Coat of Arms."

An elderly gentleman stepped from the circle and urged the young and old about him to, "Take a drink, swear, steal and lie: drink in friendship and freedom, swear to be a better friend, steal time for an act of kindness, and lie in bed reflecting upon life in a free land." Thus ended the 1985 Interage Seminar in Scotia, New York.

Sponsored by a grant from the Greater Capital District Teacher Center, the seminar was a day-long program attended by participants chosen equally from the 13–19, 20–60, and 60+ age groups. The day consisted of large and small group activities, each designed to foster the examination and sharing of life experiences and values. Activities early in the day were low-risk in order to establish group trust—human treasure hunts to find someone who "grows roses," "voted for Eisenhower," or "served in World War II," or a game called "Dance Cards" in which you find a person with a color to match the one on your card, and talk instead of dance.

Later in the day, activities demanded a higher degree of self-disclosure. For example, small groups created their own "Coat of Arms" representing: "things you enjoy doing", "symbols of beliefs or values you hold strongly", "the world's greatest problems", and "words you'd like to use to describe yourself." Each group presented its collage to the larger group where discussion followed.

Because "Coat of Arms" and other activities illustrated similarities and differences between age groups, the day fostered discussion and understanding. An eleventh-grader spoke for the younger participants when she stepped from the circle to conclude, "Older people are not as different as I thought they were."

Learning to Do More

by Jaclyn A. Card, Ph.D., Trudi Beck and Letitia Jackson

For an older mentally ill person who has lived within a State Hospital for many years, relocation in a board and care home within the community can mean regaining very essential freedoms—privacy, mobility within the neighborhood, and a more homelike atmosphere free of most of the suffocating institutional rules.

Community placement can mean change and growth for the more resilient older patients who are able to take advantage of the new environment. But for many others, whose capacity for enjoyment has been worn away by years of confinement, life in a community-based home can be as monotonous as it was within the walls of a state institution.

The transfer of thousands of patients from public mental hospitals to community settings over the past several decades is mainly attributed to the introduction of psychotropic drugs. Other major contributing factors were the availability of Medicaid to pay for the care of the infirm aged in nursing homes; expansion of eligibility under the Supplemental Security Income (SSI) program to include the chronically mentally ill (many of whom live in board and care homes); and the passage of the Community Mental Health Centers Act in 1963. Deinsitutionalization has enabled thousands of patients to return successfully to the community. But it has also resulted in the "dumping" of thousands of impaired older people into boarding and nursing homes, with few or no

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Than Pass the Time

Recreation for the Deinstitutionalized Elderly Mentally Ill

community services to help them cope with daily living.

In Missouri, the inpatient population of state mental hospitals declined from approximately 12,000 in 1959 to 1,900 in 1984. The number of deinstitutionalized, mentally ill patients in community settings has risen steadily from 900 in 1961 to over 4,000 in 1984. These individuals are predominantly white females with a mean age of 58 years at the time of community placement. Today, many of the older mentally ill in community-based settings are in their 60's and 70's.

Concerned about the well-being of chronic patients who had left state institutions, the Subcommittee on Mental Health of the Missouri Legislature conducted an investigation of the community placement program in 1981. Their investigation revealed an alarming degree of inactivity among residents of nursing and boarding homes, with typical residents spending endless hours watching television and smoking cigarettes—the sum total of their "leisure pursuits."

The Subcommittee subsequently directed the State Department of Mental Health to address this problem. To meet the challenge, the Department decided to set up a state-funded project in cooperation with the Department of Recreation and Park Administration at the University of Missouri-Columbia. Called "Leisure Is For Everyone" (LIFE), the Project is designed to improve recreation services for mentally ill residents of nursing and boarding homes throughout Missouri.

The Project's components include: direct delivery of recreation services to elderly mentally ill residents of community-based facilities; recreation training and consultation to as-

Frisbee golf is one of the many activities offered by Project LIFE.

Residents construct flower baskets for Mother's Day.

A simple bird feeder made from a pine cone can give many hours of pleasure.

sist nursing and boarding home activity directors; and research, including development of an instrument to measure changes in the leisure activities of the deinstitutionalized mentally ill. The project is supervised by a 6-person administrative team that includes a director of training and a director of services. Eight additional staff, some of whom are graduate assistants, carry out the various components of the project.

Direct Service Delivery

Three staff members provide recreation services directly to two nursing or boarding homes each semester, with the facilities visited for two hours, two days a week for a period of four months, and once a week for two additional months. The tapering off of the sessions allows for the facility's activity director to get accustomed to taking over complete responsibility for the recreation program.

The twice-a-week sessions always begin with an exercise group, proceed to a mental stimulation activity, and end up with activities that run the gamut from music, dance and drama to outdoor games.

Under the guidance of the Service Director, the graduate assistants design activities for each site—"program primers"—that are entered into a computer to create a central resource for program ideas. For example, one program primer describes a traditional drama activity built around a collection of hats—a top hat, Homberg, waitress cap, motorcycle helmet, woman's hat from the 1930's, etc. The residents are asked to select a hat that suits their fancy and to dramatize the behavior of a person likely to wear it.

Another activity centers around a bag of items with a particular smell—leaves, perfume, spices, fruit. The residents put on blindfolds, reach in for an item, try to identify it and talk about what the smell reminds them of in their own lives. When the item is cinnamon or nutmeg, some of the men cannot readily identify the spice but they associate it with applie pie or Thanksgiving—a good take-off point for reminiscing.

While some of the activities may seem awfully simple, they are a way to begin drawing residents out of their isolation. Most elderly chronic patients in boarding and nursing homes still suffer from psychopathology, have a limited attention span, and are difficult to work with. Many were placed in state hospitals in their early 20's and became so inured to the institutional routine that they don't know how to make choices when it comes to leisure time.

Reality orientation through current events, pinpointing residents' birth places on a map, making a scrapbook with mini-biographies of each resident—all are used to stimulate discussion and interaction. To get residents to enjoy the outdoors, the staff organizes walks, scavanger hunts, croquet, volleyball and even frisbee. Crafts vary from facility to facility, but popular ones are arranging dry flowers, and making wind chimes, vases, and pine cone birdfeeders. The birdfeeder is very simple—a pine cone smeared with peanut butter and rolled in birdseed, but it can provide much pleasure when hung outside a resident's window to attract all sorts of colorful birds.

A book describing the activities developed or adapted by Project LIFE, entitled *Leisure is For Everyone's Mind*, was recently published. Contact Project LIFE at the address listed at the conclusion of the article for further information.

Impact on Residents

Changes come very slowly in the residents, but they do occur. One 65-year-old woman, diagnosed as schizophrenic, who was very confused and wandered in and out of

group activities, increased her attention span from 5 to 15 minutes during the course of the program. She was also responsive to individual contact, and tried diligently to participate in the exercise group.

A 47-year-old man, incarcerated from 1969 to 1978 for violent behavior, was diagnosed as paralyzed from the waist down after suffering a severe beating in prison. When Project LIFE first visited the home, he was unresponsive, depressed and was usually asleep in his wheelchair. After several weeks, he began to smile and shake hands with the staff and twice joined in an activity. During the Project's last few weeks at the home, he became very friendly and at the farewell party, he actually stood up and danced—even though according to his medical records, he was a paraplegic.

In a boarding home in St. Louis, a resident was able to take over leadership of the exercise group, and when she later became ill and went to the hospital, another resident volunteered to take her place.

Some residents will refuse to leave their rooms, but as the weeks go by and they see that others are making crafts or enjoying a special activity, they, too, participate. In some cases, they are willing to come out only when the home's activity director takes over the program. Although this may seem like a small change, saying, in effect "Yes, I'm going to attend," involves making a choice.

When Project LIFE staff first arrives at a nursing home, the typical recreation program consists of bingo, holiday and birthday parties, coffee klatches, and perhaps some crafts. The activity director usually has many other responsibilities aside from recreation, such as taking residents back and forth to doctor or dentist appointments. Administrators often assign these duties because they don't see how recreation can take much time, but project LIFE staff know that when recreation is done correctly, it's a full-time job.

Training and Consultation

A major problem in providing assistance to elderly mentally ill people is a shortage of workers. Even more devastating is that those willing to work with this population often have no special training in dealing with the mentally ill or elderly.

In order to change this situation, at least with respect to recreation, Project LIFE conducts recreation training for facility activity directors, administrators, and other interested personnel. The 18 full-day training sessions held this year have covered such topics as communication techniques, motivation, program administration, innovative recreation activities, using community resources, fund raising and volunteer programs. Comments from training participants have been very positive. One activity director wrote on the evaluation: "I think the training sessions are outstanding. I will hate it when they come to an end."

In addition to group training, five graduate assistants offered individualized consultation on recreation to activity directors in approximately 60 nursing and boarding homes across the state last year. The graduate assistants brought along helpful recreation resources, motivated the directors to implement activities suggested in the training and offered new ideas about ways to get residents involved. LIFE consultants plan to return to the sites they have served to review the activity program, turnover in activity staff, and use of the information presented in consultations.

Instead of the "on-site" consultations, this year the Project decided to establish a consultation hotline. The staff provides advice on setting up activities, trouble shoots problems in program implementation, and refers callers to valuable recreation resources. The hotline is available to anyone in Missouri by calling 1-800-392-7348.

Research

The final component of the Project has involved the development of a Comprehensive Leisure Rating Scale (CLEIRS) that can be used by nursing and boarding home staff in Missouri and elsewhere to assess the effectiveness of recreation programs developed for residents. The need for such a scale is evident since there is no instrument available to measure the leisure behavior of the elderly, in particular, the elderly mentally ill, and there is a clear need to determine whether dollars spent on recreation are really making a difference.

Untapped Resources

In an era in which governmental funding for social programs is being cut, it is important to note that funding alternatives are available for serving the increasing number of deinstitutionalized elderly mentally ill. Cooperative efforts between state agencies are mandatory in order to promote efficiency and effectiveness of human service dollars. Project LIFE is a model program developed to demonstrate that many states do have untapped resources for serving (either directly or indirectly) this growing and often neglected population.

For further information about the program, the book containing recreation activities, or the CLEIRS instrument, contact: Project LIFE, University of Missouri-Columbia, Department of Recreation and Park Administration, 624 Clark Hall, Columbia, Mo. 65211 (314) 882-7086.

A Support Group In A Retirement Home

by Ileane Stone, M.A. and Michele Koonin, M.S.W.

A move into a retirement or nursing home is probably the most traumatic change in a person's lifetime. Yet the elderly have few regular opportunities to voice their fears, frustrations and depression over a change that infirmities or lack of a caretaker may bring about.

This is no longer the case at St. Paul's Manor in San Diego. Troubled residents can now turn to a professionally-run group where they can let out their sadness or anger in a setting where the "chin-up" pretense isn't a requirement.

St. Paul's Manor is a retirement facility for elderly people of modest means that is operated by laymen from St. Paul's Episcopal Church in San Diego. The Manor includes a 4-story building and an 11-story tower that house approximately 150 elderly people of all denominations in individual apartments and a separate 59-bed skilled nursing facility.

Although residents must be 62 or older, ambulatory and in relatively good health at the time of entry, the median age at the Manor today is 82 and most residents would be considered "the frail elderly" since they have multiple and chronic disabilities. They have survived into old age in spite of many losses—friends, family members, jobs and mobility—but the longer they survive, the more these losses may contribute to emotional problems and physical and intellectual decline.

St. Paul's Manor provides many services to residents, including 24-hour desk coverage, an intercom system connecting the desk to all residents' quarters, and emergency call buttons. There is a full-time Director of Social Services who counsels residents and families and develops educational and wellness programs, and a part-time recreation and activities director.

Other support services include dispensing of medication; assistance with bathing and personal laundry; tray services if a resident is ill or recuperating from hospitalization; and home health care provided by a licensed vocational nurse five days a week for a moderate fee.

In spite of all the above much-needed services, an outlet for expression of feelings and release of tensions was missing at St. Paul's Manor. Some residents who have always lived in a single home or apartment and now find themselves in a semi-congregate facility have difficulty coping with new situations. How do you go about making new friends at 80+ years of age? What about unresolved grief and losses? The need for a small therapy group seemed to be the answer, and the first group was started in 1984.

The theme "Staying Healthy" was agreed upon by the co-leaders as a way to interest residents, since health programs were popular at the Manor. When it came time to invite people to join the group, the Social Services Director was already quite familiar with the residents who seemed most in need for a support group to express their feelings, gain new friendships, or adjust to a new lifestyle.

Each prospective member was visited by the Social Services Director two weeks before the start of the group and was given a verbal, as well as a written, invitation. The purpose of the group was explained, how much its success depended on the resident's being present, and the time frame (8 sessions). The facilitators believed that people would be more likely to attend if the group were seen as having a termination point.

The group was made up of seven women and one man, with their ages ranging from 68 to 90. At the first session, the facilitators invited the members to select from a list of suggested topics the ones they would like to discuss at the remaining meetings. The topics they chose were: the physical and emotional difficulties of aging, death, depression, and adjusting to a different lifestyle. The facilitators decided to present a topic at the beginning of each group and to let the group process decide how the topic would be handled.

Coffee and different refreshments were served each week, and "breaking bread," so to speak, helped to ease the tensions of socializing. Since some members had a hearing problem, this had to be resolved by using a microphone. The first few times each member handled the microphone were awkward, but it soon became an accepted part of the group.

During the first two sessions, the discussion focused on the need for mutual support and for absolute confidentiality, which is essential if members are really going to feel free to share very personal information. It should also be noted that since there is still strong resistance from many elderly people to mental health services or psychiatric help, the fa-

Ileane Stone is Director of Social Services and Resident/Family Relations at St. Paul's Manor and Health Care Center in San Diego. Michele Koonin is a clinical social worker and private consultant in San Diego.

cilitators attempted to keep those overtones away from the group as much as possible.

Some of the feelings expressed during the sessions were:

- The sense of frustration and anger at one's body as the aging process occurs (bodies give out, won't do one's bidding, become tired too quickly; bones break easily and heal slowly).
- Fear of becoming non-functional and having to go to the convalescent home. One member spoke vehemently as she said, "You don't know how hard I work every day so I won't have to go to the convalescent care center. Sometimes, I feel like I can't move and I have to make myself get up."
- Anger over leaving friends behind, giving up one's home and having to pare down belongings. (Concrete losses were sometimes felt as deeply as losses of mates and friends.)
- Losing the ability to drive and to be mobile, perceived by the members as traumatic deprivations.

In general, the denial of anger—at spouses for dying, at other losses—was very evident, a denial that was often at the root of a member's depression. Many members of the group were also very self-disparaging—they berated themselves for their loss of memory, their meaninglessness to the world. Many found it difficult to accept from the facilitators and other group members compliments or evidence that some of their disabilities were not as severe as they perceived them to be. This changed for some members as the group progressed, while others needed to cling to their feelings of disability.

As the weeks went on, strong bonds developed among the group members. Residents who had started the sessions as strangers were becoming friends. Several members had been living in the Manor for the past 10 years and never knew one another. One woman, rather shy and withdrawn at the beginning, was able to express her fears of dying and received good support from the group. Another member who had just recently moved into the Manor from the Midwest spoke about the loss of her former home, old friends, and familiar surroundings. She was able to find an avenue to vent her feelings, which made her more open to receiving support in adjusting to her new environment.

As a result of the success of the first senior support group, the Manor decided to offer the group on an ongoing basis of 8-week sessions, with 3-week breaks in between.

Recently, a very special new member joined the group—a 7-year-old black poodle, named Kahlua, who belongs to one of the facilitators. Kahlua seems to know instinctively how to help the group.

One group member will talk of her loneliness and depression as she sits and holds the dog, something she was unable to do before his arrival. She has become so attached to Kahlua that she credits him for the improvement in her health, and recently remarked, "Kahlua has brought love back into my life, and I look forward to Fridays when I can see him."

As animals sometimes do, Kahlua picks up on emotions very quickly. In one session, a member who was distraught over her vision impairment got angry, snapped at one of the leaders, and then was quiet, her eyes filling with tears. Kahlua immediately went to where she was sitting and sat in front of her, looking up with concern.

Some members are less fond of Kahlua than others, because they say he can be a distraction when members vie for the honor of having him sit in their lap. But this problem was discussed, and it was the consensus that Kahlua was such a treasured member that he should be allowed to stay if the members could learn to share his affection gracefully.

After Kahlua has made his rounds and shared in the refreshments, he lies down on the floor or settles down in someone's lap. Reassured by his relaxed and comforting presence, the group turns its attention to other matters and to the ways that people can create a new type of "family" and a new sense of home.

For further information about the senior support group, contact:

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A new "member" of the support group is a 7-year-old poodle, named Kahlua.

Learning Is A Lifelong High

CUE students enjoy a lecture from a naturalist.

Seniors fashion their own curriculum at Queens College.

by Samona Sheppard, Ph.D.

If life begins at 40, it could also be said that learning truly becomes enjoyable and exciting when it is no longer required to pass a course, get a degree, or move up in a job.

Opening up new learning horizons in art, literature, music, science and philosophy should be viewed as a major challenge for all citizens in the "later" years. It was with this goal in mind that the Center for Unlimited Enrichment (CUE) at Queens College in New York City designed a unique program adapted and accessible to the older learner. The Center is a nonprofit corporation housed on the college campus.

Described by one staff member as an "Elderhostel, commuter-style," the CUE program is open to older Queens County residents. They can select from a rich variety of offerings—workshops, 2- to 8-week courses, educational day trips, social events, film festivals and forums on controversial issues.

The cost is affordable, registration is simple and convenient, schedules are flexible, and all classes and activities take place in the daytime. There are no educational prerequisites, no tests, no assignments, no pressures to prove one's competence. CUE means learning for the sheer joy of it!

Many of the courses are taught by retired professors and professionals who have a new opportunity to share their knowledge with enthusiastic and mature learners as well as to earn a modest honorarium. Other instructors are professors and adjuncts at the College and professionals from outside the academic community.

The inspiration for CUE came from a small group of older people who had been attending a free lecture series on aging at Queens College in the Spring of 1980. After the group expressed an interest in establishing a program of lifelong education, a meeting was arranged with the College president, who was most enthusiastic about the proposal.

In September, 1980, an open forum was held to explore development of the new program. Participants included senior citizens; retired and current members of the College faculty and staff; representatives from civic and service organizations, such as the Queens Office of the New York City Department of the Aging; and staff from the offices of the late Congressman Benjamin Rosenthal and the Queens Borough President Donald Manes.

Following this forum, CUE held its first formal meeting and set up committees to define program goals, develop the curriculum, recommend policies and fee structures, reach out to the community, and search for funding. The yearly membership fee agreed upon at the meeting continues to be $15, although charges for courses have been raised slightly—$30 for an 8-week course and $10 to $20 for shorter courses. The original planners of the CUE program also decided to offer a variety of activities free of charge.

After only seven months of organizing, the community was invited to the first CUE Open House in February 1981, and several weeks later, classes began, with a total enrollment of 91.

During the 1984–85 academic year, CUE membership grew to about 750. The curriculum has expanded from 6 to 21 courses of varying lengths, meeting Mondays through Saturdays from 10 a.m. to 4 p.m. Students can choose from a wide variety of subjects, including politics, economics, literature, film history, art, music, health, interpersonal relations, ethics, philosophy,

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law, psychology, folk dancing and fitness. Some courses are repeated each semester, others continued from session to session without duplicating the subject matter, and still others are completely new courses—often developed in response to members' suggestions.

In addition to classes, educational, cultural and social "happenings" are planned throughout the year. One recent day trip to study the ecology of Long Island Sound attracted 75 CUE members, one of whom exclaimed enthusiastically: "I wish I had known about CUE a long time ago. I would have retired earlier."

The activities provided free of charge to members have also expanded. In 1982, CUE hired a film expert to lead a discussion following each of the six films shown during the free summer Film Festival. According to CUE members, this discussion is frequently even more exciting than the film, and the number of viewers has grown from an average of 35 in 1981 to about 250 this year.

Other free activities include a series of eight "brown bag" lunch presentations in the Fall and Spring which include lectures, discussions, and demonstrations on a wide variety of topics; special events, such as town hall meetings on controversial issues and opportunities to "meet the authors;" and four yearly social events, including open houses that feature demonstrations of work done in art, drama, creative writing and folk dance classes.

CUE is unique in many ways. It is truly a home-grown program designed by and for older adults. As a membership organization, it involves each person in the process of planning, implementing, and evaluating the program. Class representatives maintain a two-way communication between students and the CUE office, and questionnaires are sent out each year requesting suggestions for new courses and information on special talents that members would like to share. Emphasis is also placed on social interaction—eating together, becoming friends, enjoying physical activity, sharing ideas, and just having fun.

The staff believes that CUE's rapid expansion reflects a widespread interest in community programs for lifelong education—programs that are flexible and suited to the needs of a new type of student who is looking for much more than a degree.

As one member wrote in a course evaluation: "When I became a member of CUE, I found a more positive identity to add to the image of aging daughter, housewife, mother and grandmother. I have developed into a more interesting, dynamic and secure person . . . My grandchildren no longer tell me I am 'over the hill.'"

For further information, contact:

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News Notes

HHS Secretary Otis R. Bowen, M.D.

"IMA's" To Pay For Long Term Care, One Idea Of New HHS Secretary

During his confirmation hearings, Dr. Otis R. Bowen, Secretary of Health and Human Services, stated that one of his main priorities is to ease the burden on senior citizens in the area of catastrophic care and long-term care for people with Alzheimer's and other prolonged illnesses.

Several months later, President Reagan also highlighted catastrophic care in his State of the Union Message when he directed the HHS Secretary to conduct a study on ways to provide health insurance for Americans whose life savings are threatened by a devastating illness.

Responding to questions at his confirmation hearings about the difficulties of financing long-term care that does not necessarily involve catastrophic illness, Secretary Bowen noted that he had personal reasons for being sympathetic with that problem. "I am faced with the same situation because my mother has been in a nursing home for over a year now, and I realize the catastrophic type of expense that this involves.

"The short-term solution to it, I think, will have to be worked out between the Department and mem-

bers of the Congress. The long-term solution, I really think, could be handled with the establishment of perhaps an individual medical account, sort of like an IRA, and it could be either with government or it could be private enterprise."

Dr. Bowen said that citizens could start setting aside money in these accounts at 35 or 45—during the highest earning years—and it could be paid into either a health bank in the Federal Government or into an account administered by the private sector. The Secretary added that "when an IMA account would be insufficient to take care of certain individuals, this could be helped out with perhaps the accumulated interest that would be in the health bank. It is just an idea for a long-term care solution. It would have to be almost in the next generation, but again, you have to start some time. . . ."

When asked about maintaining funding for home health care, Dr. Bowen replied, "Home Health Care is the fastest growing program in the whole Medicare system. . . . It is a good followup to the Prospective Payment program, and it probably is much less expensive than additional days in the hospital. I think there is the potential abuse of overutilization of it, and that needs to be monitored and controlled; but it has the great potential, I think, of improving the quality of care and especially the followup of care."

The Senate confirmed the former two-term governor of Indiana as Health and Human Services' Secretary on December 12, 1985. He came to HHS from the Indiana University School of Medicine in Indianapolis where he served as clinical professor of family medicine.

Dr. Bowen served as a Republican member of the House of Representatives in Indiana in 1957 and 1958 and from 1961 to 1972, holding the posts of Minority Leader in 1965 and 1966, and Speaker for three terms, from 1967 to 1972. He was governor of Indiana from 1973 to 1981.

Dr. Bowen also served on a number of federal advisory bodies, including The Advisory Council on Social Security, which he chaired, The Presidential Advisory Committee on Federalism, and The Commission on Federal Paperwork.

Born in Richland Center, Indiana in 1918, Dr. Bowen received a bachelor's degree in chemistry from Indiana University and his M.D. from Indiana University School of Medicine. He served in the Pacific Theatre during World War II as a member of the U.S. Army Medical Corps.

Honors and awards received by the Secretary include the merit award of the Indiana Public Health Association, its highest honor bestowed on an individual, for outstanding achievement in health; and the AMA's first Benjamin Rush Award for outstanding contribution by a physician in citizenship and public service.

Secretary Bowen has written extensively on health, welfare and educational matters.

AoA Funds Projects To Upgrade Legal Services For Senior Citizens

The Administration on Aging (AoA) awarded grants totalling approximately $607,000 during the summer of 1985 to three national organizations and a social gerontology center for projects to improve nationwide provision of legal services to the elderly.

The American Association of Retired Persons (AARP) in Washington, D.C. received a $150,000 grant to strengthen support for Area Agencies on Aging (AAA's) and other organizations that provide legal services to the elderly. AARP's Legal Counsel for the Elderly program will:

- train 800 lawyers, paralegals and other staff from 20 states in "elder law" and advocacy skills;
- develop two slide/tape cassette programs on legal matters and the elderly to educate approximately 23,000 senior citizens;
- recruit retired AARP members as volunteers for local legal assistance programs; and
- disseminate to legal service providers a quarterly publication containing abstracts of legal materials relating to the elderly.

As a result of a $150,000 grant awarded to the National Senior Citizens Law Center in Washington, D.C., personnel and legal services providers in the aging network will be able to access a Computer Assisted Legal Research (CALR) data base to acquire accurate information on legal issues affecting older Americans. The data base is located at the National Clearinghouse for Legal Services in Chicago, which is under contract to the National Senior Citizens Law Center. With help from staff in the Clearinghouse, attorneys and advocates in the aging network will be able to locate information quickly on decisions pertinent to the situations of elderly clients or on procedures, such as how to draft materials used in proceedings. Staff at the Law Center in Washington will offer telephone consultation on other matters, such as the legal ins and outs of Supplementary Security Income, Medicare, Medicaid, Food Stamps, long-term care and age discrimination.

The American Bar Association's Legal Commission on the Elderly received a $150,000 grant to provide technical assistance to State and Area Agencies on Aging on stimulating private bar involvement in the delivery of legal services to the elderly—including *pro bono* and re-

duced fee services and legal education for the elderly. The Commission will also develop materials for State and local AAA's and private bar groups on home equity conversion and on ways to assure a high quality of home care for the elderly through such mechanisms as standards and state laws on licensing home care workers.

A grant of approximately $157,000 went to the Center for Social Gerontology in Ann Arbor, Michigan for a variety of initiatives to upgrade legal services for older people. The Center will help Area Agencies on Aging and legal service providers to develop guides for evaluating the effectiveness of legal services delivered to the elderly; work to increase private bar involvement in assisting seniors; and plan educational programs on complex legal matters relating to the elderly for lawyers and non-lawyers. For the educational programs, the project will develop video training tapes, manuals, articles for bar journals, and other materials.

See page 35 for a list of the legal services grantees and project directors.

The Search for People Who Remember What Happened At Ellis Island

While there are many written accounts by the people who joined the mass immigration movement that helped to shape the history of this country, there are still exciting stories to record that have never gone beyond the circle of the family.

These stories have been the object of a search by the Ellis Island Oral History Project which is conducting interviews with 200 people who either immigrated through, or worked at, Ellis Island between 1892 and 1954. Of particular interest, according to the interviewers, are the experiences of immigrants who came through the island before 1924. The project is being sponsored by the National Park Service and the Statue of Liberty-Ellis Island Centennial Commission and Foundation.

"We're looking for human interest stories and recollections of the processing through Ellis Island," explains Dana Gumb, coordinator of the project. He notes that most immigrants spent only several hours on the island but that some were detained there for days or weeks due to illness or other reasons. "The people who were there overnight may have particularly interesting stories to tell."

Do immigrants remember the questions officials asked or the medical exam, and where did they sleep, how were they treated, and what did they eat? Gumb says that some immigrants comment that Ellis Island marked the first time they ever saw a banana, ate a piece of white bread, or were presented with a bowl of oatmeal.

While these details may not seem terribly significant, they often trigger memories that can help to create an accurate picture of the immigrant's experience—the fears, the joy and the expectations. The emotional significance of the day of arrival in America was highlighted in a recently published account by a woman who retold her father's story:

> *My father, Josef Jakab, came to America from Hungary as a 12-year-old boy. He was sent alone by his parents who dreamed that he would find a better life than they had as serfs on the estate of a titled landowner. After 16 days at sea, the boat he was on drew near the statue, and the people crowded into steerage came running up on deck. Everyone broke into song and hugged each other. Then they all fell silent in prayer as the enormity of their journey took hold. . .*

People throughout the country interested in participating in the project should write to: Ellis Island Oral History Project, P.O. Box 20375, Greeley Square Station, New York, N.Y. 10001. The project is also looking for people in the New York City area who are willing to volunteer to help with screening mail that comes in and arranging telephone interviews.

New Psychology And Aging Journal

The American Psychological Association has announced plans for a new quarterly journal entitled "Psychology and Aging." The first issue is scheduled for the first quarter of 1986.

Contact: Dr. Powell Lawton, Editor, Psychology and Aging, American Psychological Association, 1200 17th Street, N.W., Washington, D.C. 20036. (202) 955-7600.

Foster Grandparent Mariano Meneses with Freddie Lopez.

20th Anniversary of Foster Grandparents

On the outskirts of San Antonio in a small dilapidated house, 69-year old Mrs. Ofelia Esparza, plays with a year-old child in diapers on a bright red couch—the only furniture in the room. The youngster is one of nine children. The youngest is one week old. The mother is 28.

Mrs. Esparza does not live in the neighborhood, nor is she a relative of the family. She is a volunteer from one of the San Antonio Foster Grandparent programs that place older people as "model parents" in homes of families involved in child abuse or neglect.

By setting an example of patience and firmness, the volunteer is often able to "teach" parents how to deal with the frustrating everyday problems of raising children—without losing control and resorting to abuse. Working in the homes of families "at risk" of abuse can be, and often is, a "pressure cooker" environment for Foster Grandparents, but most of them find such assignments rewarding. Mrs. Esparza speaks for all of the Foster Grandparents when she comments, "I want to be where I'm really needed. When I see change in the mother, I'm so proud I'm doing something that counts!"

The San Antonio project demonstrates that the Foster Grandparents Program, which celebrated its 20th anniversary last fall, has expanded the roles and challenging opportunities offered to its older volunteers. When the program started out, many were assisting only handicapped or ill children, but the volunteers are now also working with victims of child abuse and neglect, teenage parents, and status offenders.

ACTION, the national agency on volunteer services that administers the Foster Grandparent Program, reports that there are currently 19,000 low-income men and women over 60 providing 20 hours of personal attention a week to children with special needs. Volunteers receive $2.20 an hour stipend, a free meal on the day they serve, and the cost of transportation to and from the institution or residence where they work.

The 20th Anniversary of the program had special significance for San Antonio, since the city was the home of the first Foster Grandparent project which opened in September, 1965.

In addition to assisting in the homes of families "at risk" of child abuse, Foster Grandparents in San Antonio help out at the Holmgreen Memorial Children's Shelter. Forty percent of the children are taken to the Shelter by the police due to a family crisis, such as abuse, neglect, abandonment, and incarceration or hospitalization of parents. The grandparents work one-to-one with children needing special attention. Tasks range from dressing, feeding, playing games, reading stories and helping with school work to giving love to a frightened child.

At two other sites in San Antonio—Santa Rosa Children's Hospital and the Medical Center Hospital—Foster Grandparents work with the Play Therapist and assist in the different medical units. The Grandparents alleviate some of the concern parents have when they are unable to be with their child during the day due to their jobs or the distances they must travel if the child has been flown to San Antonio for treatment.

Foster Grandparent supervisors at the two hospitals note that "a lot of times the children will do things for the Grannies they will not do for the staff. The Foster Grandparents are

Foster Grandparents Ignacia Ortega and Delfina Cuellar.

warm and loving and kind. They spend more time with the children than the staff can and they really apply themselves and get involved."

In San Antonio, Foster Grandparents receive 40 hours of in-service training prior to performing their first assignment and on-going training of four hours a week. Also when appropriate, there are once-a-week meetings with the social worker and the client.

According to Mrs. Linda Lee Davis, Director of San Antonio's Foster Grandparents Program, "Foster Grandparents are the survivors and can handle many difficult situations with great expertise. Supervisors in the institutions where Foster Grandparents serve have been known to use the word 'miracle' to describe some of the changes Foster Grandparents bring about in the children."

Mr. Santos Serna, 69, explains why he likes being a Foster Grandparent volunteer. "I'm still a part of the community as a working senior citizen and still participating."

For further information about the San Antonio Foster Grandparents Program, contact Mrs. Linda Lee Davis, Director, 4502 Medical Drive, San Antonio, Texas 78284, (512) 223-6361, Ext. 501. Information about other Foster Grandparent programs can be obtained from local Area Agencies on Aging.

15 AoA Grants Awarded To Expand Housing Options for the Elderly

The Administration on Aging awarded grants totalling $1.6 million in the summer of 1985 for 15 projects designed to improve housing and living conditions for the elderly.

The projects fall into three major categories: research on the long-range housing needs of the older population; improving collaboration among community agencies in the development of housing for the elderly; and dissemination of information to the public on housing options for older Americans. The awards also included a grant to the National Fire Protection Association in Quincy, Massachusetts to conduct workshops throughout the country on prevention of fires in rooming houses and board and care homes for the elderly.

Housing Projections

The Urban Institute in Washington, D.C. received a grant for a 3-year project to develop a data base capable of projecting the elderly's housing needs through the year 2010. The project plans to produce

economic and demographic data on elderly-headed households as of 2010, including their housing circumstances, and to estimate the probable changes in their housing situation under several different policy scenarios.

Agency Collaboration

Two projects will concentrate on encouraging collaborative efforts among agencies on aging, state and local housing agencies, private developers, financial institutions, and architects in expanding and improving housing for older Americans.

The Council of State Housing Agencies in collaboration with the National Association of State Units on Aging, both in Washington, D.C. will produce a variety of technical assistance documents on collaboration among state agencies in the planning, financing and managing of housing for senior citizens. The reports will include case studies of exemplary practices, with emphasis on integration of housing and social services for the elderly.

In Florida, the Department of Community Affairs in Tallahassee and the Miami Jewish Home and Hospital for the Aged will develop six "model action" packages on practical approaches for achieving collaboration among state and local governments and the private and voluntary sectors in expanding housing for the elderly. The project will also draft model zoning codes that will permit accessory apartments and other housing alternatives for older people.

Education on Housing Options

The American Association of Retired Persons in Washington, D.C. will establish Consumer Housing Information Services for Seniors, manned by trained volunteers, in four states (New Jersey, Texas, Idaho and Missouri) to provide information on housing options at the local level, including home equity conversion plans. AARP will also develop a model workshop on housing alternatives for the elderly for use in the 10 Federal Regions.

Radio and TV spots to educate the public about housing options and relocation assistance for older persons will be produced by the University of Bridgeport in Connecticut for national dissemination through state broadcasting associations.

New Hampshire, New York, Delaware and Colorado will develop statewide networks to provide information on housing for the elderly. The networks will make use of toll-

free telephone lines and counseling, radio and TV presentations, newspaper articles and workshops. The grantees include the New England Non-Profit Housing Development Corporation in Manchester, N.H.; Cornell University in Ithaca, N.Y.; the Delaware Division on Aging; and the Colorado Association of Homes and Services for the Aging.

Interfaith Ministries of Nebraska in Lincoln will hold eight workshops for older Nebraskans—especially those living in rural areas—on shared housing and other alternative living arrangements that can help older persons to avoid institutionalization. The project will also conduct seminars for the clergy and lay leaders on counseling the elderly and their families regarding housing options. In addition, the organization will develop for congregations and interfaith groups in various regions lists of state and local experts, architects and other professionals who can provide assistance in developing housing for senior citizens.

United Way of Dayton, Ohio will produce "Old Friends," a 26-week TV series on housing options and services for the elderly, which will be aired on each of Ohio's eight public broadcasting affiliates.

A corp of volunteers of all ages will be trained by the West Central Florida Area Agency on Aging to operate a toll-free telephone line offering information on available housing for seniors. The volunteers will also offer individualized assistance on housing matters to seniors at 20 centers in the region.

The Housing Bureau for Seniors in Ann Arbor Michigan will attempt to reach large numbers of seniors in Washtenaw County with information on housing through newspaper articles, radio shows, workshops and regular visits to programs for the elderly.

In New York City, the East Bronx Council on Aging will establish a community-wide housing resource center to provide information, advocacy services, advice on housing entitlements, and one-to-one counseling to seniors. The project will also establish the first shared housing program for the elderly in the Bronx.

See page 35 for a list of the housing grantees and project directors.

AoA Grants Focus on Support for Families of Alzheimer's Patients

The Administration on Aging awarded grants totalling about $1.1 million in the summer of 1985 for 12 projects to assist Alzheimer's victims and their families in dealing with the catastrophic emotional and financial consequences of the disease. The AoA-funded projects take several different approaches to strengthening family and community supports for older persons with Alzheimer's.

Two projects are aimed at increasing public awareness and understanding of the disease. One, under the leadership of the Hillhaven Foundation in Memphis, Tennessee, will conduct a series of seminars for health care professionals and forums for the general public. The other, based at the University of Southern California, will conduct a survey to determine the public's current knowledge and perception of Alzheimer's Disease.

Five projects are demonstrating different models of providing training to caregivers:

- The New York City Department for the Aging will educate and assist family members in dealing with legal problems stemming from the patient's progressive impairment.
- Issues of particular concern to rural caregivers are being addressed at West Virginia University.
- Researchers at the University of Chicago will evaluate the use of behavioral procedures, in combination with family interventions and adult day care, in preventing institutionalization of Alzheimer's patients.
- A team at the University of Southern California will develop telephone networks that use older persons to provide both information and emotional support to Alzheimer's caregivers.
- The Tri-City Community Mental Health Center in East Chicago, Indiana will demonstrate church-based counseling services as a model for other communities.

Three additional projects will offer innovative approaches to providing periodic relief to family members from the burdens of caregiving, with emphasis on the recruitment and training of homecare, or respite care, workers. These projects are based at the Connecticut Department on Aging, the University of South Florida, and the Alzheimer's Disease and Related Disorders Association of Eastern Massachusetts.

Of the two remaining projects, one, to be conducted by the University of Kansas College of Health Sciences and Hospital, will coordinate efforts in a 4-state region (Iowa, Kansas, Missouri, and Nebraska) to develop and implement model family support groups for rural areas. The second project features a State residential resource center—including a board and care home, an adult day treatment and respite program, and an evaluation unit—that will be developed under the leadership of the Bureau of Maine's Elderly.

See page 35 for a list of the Alzheimer's grantees and persons to contact for information about the projects.

An attorney for the AoA-funded Legal Hotline for Older Americans gives a caller legal advice.

Phone-A-Lawyer Project Gives Seniors Free Or Lower Cost Legal Help

If you can call a doctor to ask about medical problems, why not a lawyer to allay fears over uncomplicated legal matters? This just isn't the way the legal profession operates in most parts of the country—unless you are fortunate enough to be a senior citizen living in Allegheny County, Pennsylvania.

Residents over 60 years of age of Pittsburgh and other cities and towns in the county now have access to free legal advice over the telephone—courtesy of the Legal Hotline for Older Americans Project, which is funded by the Administration on Aging and sponsored by the Legal Counsel for the Elderly Program of the American Association of Retired Persons. The project will also do routine legal work for low fees, such as simple wills, and refer callers to a panel of attorneys for more complicated matters—still at below the usual rates.

Established as a model project in June 1985, the hotline is currently staffed by five paid attorneys and two lawyers who volunteer their services. "We get questions on everything from estate planning and eligibility for public benefits programs to consumer issues and divorce," says the project's Managing Attorney, Monica Kolasa.

Estate planning is a frequent concern, reports Ms. Kolasa. "They want to know whether or not they should make a will, what are the inheritance consequences of not doing so, and what happens to their assets if they go to a nursing home." She says callers have often read something in the paper about how to avoid probate, and "they want to make sure the inheritance is passed on to their children with the least amount of burden."

When it comes to protection of assets in case of nursing home placement, the attorneys can tell the caller how Medicaid regulations are likely to be applied in the county or point out areas of State law that may not be in conformance with Federal Medicaid regulations and are therefore open to challenge.

Consumer problems are also high on the elderly's list of concerns. They may call in the middle of a rain storm upset about ceilings that still leak despite a recent roofing job. "We tell them to get another roofer to come in and look at the problem and estimate what it will cost to fix it. Then we advise them to ask for that amount in damages, to gather the necessary papers and photographs for evidence and to go down to Small Claims Court to file a complaint and pay a small charge. The whole problem may be handled simply without resorting to a lawyer."

The elderly can't make a phone call to anywhere else and get this kind of legal advice, notes Ms. Kolasa. Neighborhood Legal Services requires low-income people needing help to make an appointment and come to the office, and Lawyer Referral Services, common in many cities, will only recommend and refer you to an attorney.

"Many older people feel much more comfortable asking questions on the telephone than they do coming down to a lawyer's office," comments Ms. Kolasa. "A lot of the questions are rather simple ones—but the answers produce a great deal of peace of mind. Many times, the elderly get so upset over a matter that they can't sleep."

When a call comes in, the lawyer on duty enters the person's name, address and phone on a computer, along with all the details surrounding the question asked. "If the person calls again, the attorney can get an instant record on the background of the problem. For first-time callers, the computer can be used to do a "conflict of interest check" to find out whether the attorney has handled a similar question from a spouse or relative in the past. "You'd be amazed at how well the attorneys have adapted to the computer and how much of a help it is," comments Ms. Kolasa, who also notes that it enables the project to do without expensive clerical staff.

If a caller wants a simple will, the project staff will do it—$45 for an individual and $70 for a couple—by sending out the necessary forms through the mail. After the forms are returned, the attorney drafts a will, sends it out for approval and invites the caller downtown to the project office to execute the document.

For $20 (the fee is waived for low-income callers), the project will carry out simple legal procedures such as writing a letter or making a phone call to a third party. If it appears, however, that the matter will require sitting down with a lawyer, the staff will refer the caller to one of the attorneys on contract to the project.

An initial fee of $15 entitles the caller to a half-hour consultation with the attorney. Each attorney's contract with the hotline includes a fee schedule—a $60 hourly fee, often with a maximum charge, for example, of $250, despite the number of hours of work involved. This enables the project to inform people in advance of the fees to expect after the consultation—which are still below the customary hourly charges.

The beauty of the system, notes Ms. Kolasa, is that the $15 initial consultation fee and 16% of any additional hourly fees are returned to the project to cover the daily costs of operating the hotline service. The eventual goal, of course, is to become self-sustaining and to do without a government grant.

However, Ms.Kolasa says that even more important than the sound method of financing is the accessibility of the hotline and referral service. "This method of providing legal services to the elderly breaks down access barriers, such as the mystique surrounding lawyers and transportation problems, which have impeded use of legal services by older people."

Right now, she says the project is receiving 25 calls a day, but that number often goes higher, especially after publicity efforts—public TV ads, brochures distributed by the Area Agency on Aging and local senior centers, newspaper articles, and staff appearances on radio and TV shows aimed at the senior audience.

"We're hoping, at some point, to expand the service statewide," notes Ms. Kolasa, "by putting in a state toll-free number and recruiting attorneys from local areas. Our computer could handle the increased client load without much additional expense and deliver a really efficient service."

If the model project in Pittsburgh continues to be a success, telephone legal services, backed up by computers and a small but well trained staff of attorneys, may introduce a new kind of competition into the legal profession.

For further information, contact: Monica Kolasa, Legal Hotline for Older Americans, P.O. Box 23180, Pittsburgh, Pa. 15222 (412) 263-3433.

Cash Incentive Awards Increase Productivity At Senior Meals Sites

A new cash incentive system designed to raise meals productivity at senior nutrition programs in Washington County, Oregon is believed to have played a significant role in achieving a 16 percent increase in the number of meals served to seniors in the county in Fiscal Year 1984–1985.

According to Robert Tepper, supervisor of the Washington County Area Agency on Aging (AAA), meals productivity remained relatively static prior to the introduction of the incentive program by the agency in the fall of 1984. Tepper recently explained that, at that time, the agency set aside $20,000 in Older Americans Act Title III-C nutrition funds for the incentive awards which would consist of 50¢ per meal for all meals that exceeded the number served by a nutrition site during the previous fiscal year.

During the first half of the year, the AAA gave a total of $4,253 to seven providers who were able to increase the number of meals served over the previous year, with the awards ranging from $89 to $1,772, and averaging $608. For the second half of the year, $6,701 was divided by six providers, with awards ranging from $369 to $3,027, and averaging $1,117.

The incentive funding amounted to $10,954, about four percent of the Title III-C allotment for the county. The remaining funds of the $20,000 originally reserved for cash awards were carried over for use in the nutrition program the following year.

Nutrition funds are divided equally among eight multi-purpose senior centers that also serve as nutrition sites in Washington County. Five of the centers prepare meals on site and three purchase meals; sixty-five percent of the meals are served at group programs for seniors and 35 percent are home delivered.

Marge Stewart, director of the AAA's Nutrition Advisory Committee and the volunteer manager of the Sherwood Senior Center, noted that the Committee had wanted to reach more older people with nutrition services and that the incentive award system helped to achieve that goal. She asked seniors who dine at her center to invite people they knew or to give the names of potential participants to the outreach worker.

Another center director was generally supportive of the incentive system but voiced some reservations. She said the importance of reaching more seniors in need should be its own incentive for increasing meals productivity. The director of a senior center that did not receive any

awards felt that established centers that had performed very good outreach over the years were at a disadvantage because they could not significantly increase their participation. She said she is "not particularly for it" and would like the money to go directly for services such as Meals on Wheels.

For further information on the incentive system, contact: Robert Tepper, Supervisor, Washington County Area Agency on Aging, 150 N.E. Third Ave., Hillsboro, Ore. 97124 (503) 640-3720.

Lottery Funds Help Pay Drug Costs For 376,000 Pennsylvanians

Revenues from Pennsylvania's State Lottery are being creatively used to help senior citizens get needed prescription drugs at affordable costs.

On July 1, 1984, Pennsylvania inaugurated the nation's largest prescription assistance program, called PACE (Pharmaceutical Assistance Contract for the Elderly). Authorized at a level of $300 million for its first three years, PACE was designed to allow lower-income persons aged 65 and older to have physician prescriptions filled at a cost of only $4. Revenues from State Lottery funds pick up the balance of prescription costs, which have averaged approximately $9.83 each.

After 10 months of operation, the program was able to raise income limits for participants by $3,000. The new limits are $12,000 for single persons and $15,000 for married couples aged 65 and older. To participate in PACE, individuals must annually complete a simple application form available from the State's 50 Area Agencies on Aging, 500 senior centers, and 2700 pharmacies.

Officials reported last fall that the program's annual cost could run anywhere from $310 to $354 million, instead of the $300 million originally anticipated, due to increased enrollment and rising drug costs. Fraudulent claims are also being investigated as a possible factor contributing to higher costs. The State Department of Aging has established both a toll-free hotline and a special post office box address for suspected abuse of the PACE program by senior citizens, pharmacists or dispensing physicians.

As of November, 1985, more than half of the participants in PACE were aged 70–80, with 72 percent being women, 33 percent married, and 79 percent living in private residences. According to Secretary of Aging Alma R. Jacobs, "Fully one-third of all PACE subscribers live alone on incomes of less than $6,000 a year, which is very near the poverty line."

Noting that more than 400,000 older persons were enrolled in PACE during its first 16 months of operation, one program official remarked, "The real winners of the State Lottery are Pennsylvania's senior citizens!"

The Department of Aging has also kicked off a statewide drug education program to prevent elderly persons from misusing drugs and medicines. Ms. Jacobs says studies indicate that at least 30 percent of elderly persons make serious errors in the use of prescription drugs and over-the-counter medicines.

The drug education program includes training local service providers to inform older persons about drug misuse and also provides physicians with a self-study, university-based course on elderly-related diseases and effective medications.

A drug education brochure, "What Should I Know About Medications," and a "Senior Citizen Passport" designed to help older persons organize and keep track of their medications have also been made available to older persons through pharmacies in Pennsylvania. The Medication Passport was developed with the assistance from Blue Cross/Blue Shield and the State Pharmaceutical Association.

Additional information on the PACE program can be obtained from the Pennsylvania Department of Aging, 231 State St., Harrisburg, Pa. 17101.

California Provides State Funds for Health Insurance Counseling

The California Department of Aging has established a Health Insurance Advocacy and Counseling Program to help seniors explore supplemental health insurance to provide protection against high medical expenses which may not be covered by Medicare.

"Deciding whether one may need supplemental health insurance is a difficult question for seniors in view of the array of health plans available and the complexity of the Medicare program," said Alice Gonzales, Director of the California Department of Aging. "The Health Insurance Counseling and Advocacy Program represents one of the first state-funded efforts in the nation to assist seniors in this area."

Under legislation signed by Governor George Deukmejian last year, an appropriation of nearly $425,000 was made from the General Fund for the 1985–86 Fiscal Year to carry out the new program.

The California Department of Aging selected 11 local organizations to help seniors determine which supplemental health insurance program best matches their personal needs. These organizations will offer information and legal assistance to Medicare beneficiaries. The organizations will also recruit and train volunteers on health insurance and

Medicare matters to serve as counselors.

The 11 agencies awarded grants cover an area where more than 75 percent of California's seniors reside. In the legislation, preference was given to organizations that presently provide free legal services and have managed efforts similar to the Health Insurance Counseling and Advocacy program..

"The Deukmejian Administration wants the dollars to be used effectively to deliver the information to as many older Californians as possible," stressed Alice Gonzales.

New Guide Helps Seniors In R.I. To Select Subsidized Apartments

Older people in Rhode Island faced with the necessity of moving to a subsidized apartment can now obtain a booklet that will help them to make this difficult transition.

Called *Apartment for Rent: A Guide to Public Housing for the Elderly*, the booklet was written by Dr. Mary Kalymun, an Environmental Gerontologist, and a member of the Program in Gerontology at the University of Rhode Island. Made possible by a grant from the Kimball Foundation in Providence, the booklet is being distributed by The University of Rhode Island and to senior meal sites and libraries by Rhode Island's Department of Elderly Affairs.

"Moving is always traumatic, but it is especially so for the elderly," notes Dr. Kalymun, whose booklet provides a preview of the entire process of relocating.

While much of the information is useful to elderly apartment hunters throughout the country, the chapter on "The Application Process" is geared specifically to elderly citizens of Rhode Island. Some of the topics covered are how rent is determined, the waiting list period, state policy on transferring from one apartment to another, and rules regarding overnight guests and pets.

In her Chapter, "Choosing A Place to Live" Dr. Kalymun suggests that apartment hunters visit the neighborhood several times to get a "feel" for the area and to meet and talk with neighborhood residents. Checking the distance from the apartment building to banks, shopping areas, churches, and medical centers and other needed services is advised.

"The Inside Story" considers the interior of the apartment as well as such services as trash removal, shampooing of rugs and window washing. This chapter also stresses that social activities available to residents should be an important concern.

To prepare the applicant for the kinds of information that will be required before the apartment can be rented, the booklet includes a sample pre-application form. Several pages of sample floor plans are also included, some of which are barrier-free apartments adapted for the handicapped.

At the end of the booklet, Dr. Kalymun provides an extensive personal checklist that allows the apartment hunter to make comparisons of up to three housing facilities--the number recommended for the final selection process.

States Dr. Kalymun, "*Apartment for Rent* is written so that older adults can think about what's really important and stay in control of the move. This reduces anxiety, and it also helps with the adjustment to relocation."

Home Equity Conversion Programs Move Ahead In Mass., Conn. and Me.

In recent months, new home equity conversion programs have been launched in a number of different communities across the country. Although these programs often differ widely in terms of eligibility requirements and the types of financing mechanisms used, their basic purpose is the same: to provide older homeowners with monthly cash flow based on the value of their homes. The older person can take advantage of the equity which has accumulated in his or her home and, at the same time, continue to live there.

In Massachusetts, the Boston Commission on Affairs of the Elderly (which is also the city's Area Agency on Aging) has been participating with the city's Community Action Agency, Action for Boston Community Development (ABCD), and the Massachusetts Department of Elderly Affairs in a pilot program which offers expert counseling services to older persons who are considering whether they should apply for home equity conversion benefits. The pilot program currently serves the metropolitan Boston area and Cape Cod.

The purpose of the counseling is to help older homeowners assess their individual housing and income needs and to determine which home equity conversion vehicle, if any, is appropriate.

The forms of home equity conversion available to Massachusetts' residents are the reverse mortgage,

the sale/leaseback plan and property tax deferral.

A reverse mortgage is just that; the bank pays the homeowner a fixed amount of money each month instead of vice versa. Repayment of the loan plus the interest (set at slightly below the prevailing rate) is deferred for a period ranging from 5 to 7 years. At the end of that time, the loan and interest must be repaid, usually necessitating sale of the house. A reverse mortgage is often particularly appropriate for elderly people who will require in-home professional care for a several years before entering a nursing home.

In a sale/leaseback arrangement, the homeowner sells the house to an investor at slightly below the market rate and receives a guaranteed right of lifetime residency. The elderly person, who receives the money from the sale either in a lump sum or in monthly installments, then leases the house back from the investor at a fair market rent. In addition to the benefit of continuing to live in a familiar environment, the elderly person is relieved of the burdens of home ownership, such as payment of property taxes and home maintenance costs. If the person dies and the investor still has mortgage payments to make, the balance would be paid to the person's heirs.

Tax deferral is available statewide to homeowners in Massachusetts whose incomes do not exceed $20,000. Under the plan, homeowners can defer property taxes until the property is sold, so long as the taxes do not exceed 50 percent of the value of the home. The homeowner is charged 8 percent interest for the loan.

In addition to providing direct counseling to older homeowners, Action for Boston Community Development program staff are serving as consultants to other agencies in Massachusetts that are interested in setting up similar home equity conversion counseling programs.

For further information, contact: Senior Home Equity Program, ABCD, 178 Tremont St., Boston, Mass. 02111 (617) 357-6000, extension 289.

In Connecticut, the efforts of the Governor's Task Force on Home Equity Conversion have led to the establishment of several new programs. In Middletown, the Farmers and Merchants Savings Bank has begun offering home equity conversion services to homeowners of Middlesex County who are 68 years or older. Additionally, the People's Savings Bank, which has branches throughout the State, has announced that it will begin offering home equity conversion programs to its customers.

The Connecticut Housing Finance Authority (CHFA) has also set aside $5 million to provide reverse mortgages to older homeowners. Income eligibility levels are set at 50 percent of an area's median income and vary by county. Limits range from a high of $20,925 in Fairfield County (New York City suburbs) to a low of $13,150 in Windham County (northeastern Connecticut). Loan amounts will be made for 80 percent of a home's appraised value up to a maximum of $80,000 and for a term of 10 years.

For further information on the Housing Finance Authority program, contact: Reverse Annuity Mortgage Program, Connecticut Department on Aging, 175 Main St., Hartford, Conn. 06106 (203) 566-7772 or call the Governor's toll-free hotline 1-800-842-2220 and ask for the Connecticut Department on Aging.

Maine has also placed an emphasis on home equity conversion and has broadened the usual definition of the concept to include shared housing and accessory apartments. Through a grant from the Administration on Aging, The Bureau of Maine's Elderly set up a special project to develop innovative models of home equity conversion and to educate the public and professionals about various home equity plans.

The project conducted 10 consumer forums on home equity conversion, with organizational assistance from the state's five Area Agencies on Aging, and later developed a technical assistance manual on the subject.

The project was able to develop the following:

■ *A Sale/Leaseback Congregate Residence* — With $40,000 in grant funds, the project, purchased a nine-room house in Saco from an elderly couple in exchange for building them an apartment on the first floor of the house and guaranteeing them lifetime residency. Maine State Housing Authority assisted in providing HUD moderate rehabilitation subsidies to allow the rest of the house to be converted into six living units for low-income elderly.

■ *Shared Housing* — The Central Maine Area Agency on Aging conducted a public education campaign on the simplest method of home equity conversion — sharing your home with someone else on a rental bases. Fifteen elderly individuals were identified and assisted in finding a home to share.

■ *Accessory Apartments* — The project identified an interest among the elderly owners of large old homes in converting part of their residence to an income producing apartment. The Maine State Housing Authority made available home improvement loans of up to $15,000, and five individuals took part in the demonstration.

For further information, n Maine's home equity conversion project, contact Ms. Patricia Riley, Director, Bureau of Maine's Elderly, Department of Human Services, State House, Station No. 11, Augusta Maine 04333. (207) 289-2561.

Publications

Loss, Grief & Care. Quarterly Journal edited by Dr. Austin H. Kutscher. Haworth Press, Inc., 28 East 22 St., New York, NY 10010. Subscription rates: $24 for individuals ($7 introductory discount on prepaid and credit card orders), $32 for institutions, and $40 for libraries. $2 postage and handling.

According to the editor, Dr. Austin H. Kutscher, President of the Foundation of Thanatology in New York City, *Loss, Grief & Care* "will function as a means of communicating the crucial issues of psychosocial care for chronically, critically ill, and terminally ill patients and their family members. It will view these issues from many perspectives, including those of multiple diseases, multiple topics, and multidisciplinary caregiving. . . "As a repository for an ever-expanding literature of thanatology, this journal will be a significant resource, documenting . . . scientific and humanistic approaches to dying, death, loss, grief, and bereavement."

The new quarterly will feature articles on a variety of topics including current research in the field of thanatology; the state of the art in educational programs for practitioners and students in the allied health sciences who serve as caregivers for the dying and the bereaved; the dilemmas imposed by attempts to achieve proper allocation of resources relating to health care; and the ethical and moral issues raised by advances in medical technology and biological research.

The editor welcomes submission of papers for publication consideration. Prospective authors should first request an *Instructions for Authors* brochure from: Dr. Austin H. Kutscher, Editor, *Loss, Grief & Care*. Foundation of Thanatology, 630 West 168th St., New York, NY 10032.

Practitioner's Guide on Training Older Workers and **Older Worker Employment Comes of Age: Practice and Potential.** National Commission for Employment Policy, Attn. Ms. Shirley Percy, 1522 K St., N.W., Suite 300, Washington, D.C. 20005, (202) 724-1550. A limited number of copies of these publications are available free.

The National Commission for Employment Policy, an independent federal agency set up to advise the President and Congress on national employment and training issues, has published two comprehensive guides designed to improve employment conditions for older workers.

A Practitioner's Guide for Training Older Workers, is a technical assistance handbook written for persons involved in developing and running programs using 3% set-aside funds for persons 55 and older under the Job Training Partnership Act (JTPA). In addition to providing information to improve the operation of JTPA-funded programs, the guide presents strategies for finding older people employment in the private sector that are based on the results of Commission-sponsored research.

There are four main sections to the guide. The first presents an overview of the Job Training Partnership Act and its provisions regarding services to older workers. Part Two, "Program Planning and Development," discusses several aspects of designing a program from the perspective of older workers, employers and program operators. Part Three, "Program Operation," outlines the various components of JTPA programs for recruiting, training and placing older workers. The last section discusses the data needed to assess a program's effectiveness, and how evaluation can improve program operation.

The second guide, *Older Worker Employment Comes of Age: Practice and Potential* examines the forces affecting older workers and identifies key areas where changes could be introduced. Who can make these changes, and how, is a major focus of the guide. The intended audience includes businesses, unions, public

Dick Swartz

sector employers, local and state government offices, pension commissions, agencies on aging, and community organization personnel.

Following the introduction, there are seven sections, along with an appendix.

- *The Status of Older Workers* discusses who older workers are, how many there are and will be, and what problems they face.
- *Older Worker Employment Issues* highlights four key, cross-cutting issues affecting older workers: benefits and compensation, work arrangements, education and retraining, and marketing and placement.
- *Public, Private, and Community Policies and Practices* identifies policy tools, such as laws forbidding age discrimination or tax credits for firms employing older workers, that can be used to address the needs of older employees.
- *Employer and Labor Initiatives* discusses employer and union interests in addressing older worker issues and examines employer practices that assist older workers, such as rehiring retirees as consultants or allowing pension accruals to continue after age 65.
- *State and Local Policy Actions* discusses the interests of state and local governments in promoting older worker employment and in finding solutions to older worker issues that affect employment, such as the need for education or retraining.
- *Community-Based Efforts* reviews some of the ways community groups of various types have addressed older worker issues, and highlights some of the more successful initiatives.
- *Developing Older Worker Employment Strategies* illustrates how corporations, government, and community groups can develop strategies to meet both the labor needs of employers and the interests of older workers.

Alternative Housing Arrangements: A Selected Information Guide. Written in consultation with Patrick H. Hare. HUD USER, Dept. 1, P.O. Box 280, Germantown, Md 20874. $5.00. Make checks payable to HUD USER.

Alternative Housing Arrangements: A Selected Information Guide offers a descriptive general article and abstracts of books, reports and other materials on shared housing, accessory apartments, and ECHO housing or "granny flats."

The publication analyzes the current status of alternative housing forms, shows their relevance to today's housing market, and suggests strategies communities can use to promote alternative housing without undermining existing property values.

In an introductory article, Patrick H. Hare observes that even when accessory apartments, shared housing or granny flats are legalized through zoning or other ordinances, very few people take advantage of the new options. According to Hare, this is not because the housing options are unsatisfactory to the participants (studies show the opposite), but because communities are not employing effective marketing and public awareness strategies.

Hare also makes a plea for involving the private sector in development of alternative housing, since public funding is shrinking and the private sector may have a greater capability to market the "new" housing ideas. Discussing accessory apartments, Hare says: "The Savings and Loan industry could make money from loans for installation, and real estate agents could make money by managing units for older homeowners, as well as by selling homes more easily because buyers would have the rental income from an apartment." Hospitals and home health care agencies might also become involved in shared housing and other arrangements because of the incentive under the new Prospective Payment System to discharge patients as soon as possible from the hospital to secure living situations that offer some capability for caretaking at home.

Hare comments: "There may not be enough profit potential for any one of these groups to put forward an incentive . . . by itself. However, each would be likely to benefit if they were all brought together in a marketing partnership under an Area Agency on Aging or a similar organization."

Abstracts of reports and books included in the HUD booklet cover a broad range of topics, including planning for group residences; the art of matching homesharers; different housing alternatives for rural residents; innovative zoning; ways local governments can address the problems of population density, sewer overload and attractiveness of second units; and technical standards for the design, construction and installation of granny flats. The booklet also includes a list of national organizations that offer information on alternative housing forms.

Elder Neglect and Abuse: An Annotated Bibliography. Compiled by Tanya F. Johnson, James G. O'Brien, and Margaret F. Hudson. Greenwood Press, 88 Post Road West, Box 5007, Westport, CT 06881 (203) 226-3571. Hardbound $35.

This annotated bibliography brings together selected information on materials written since 1975 when the plight of maltreated older people was first studied systematically as a social problem. It focuses on maltreatment in family settings. Entries are classified according to discipline and substantive issues in the abuse and neglect of the elderly.

The information in the volume is organized into several sections. A review of research, policy, and practice is presented first. This is followed by an extensive annotated bibliography which contains a variety of references, including books, journal articles, articles from the popular press, reports from investigative committees, research reports, and pamphlets.

Next, an unannotated bibliography lists information pertaining to both family and non-family settings. It includes federal and state publications on neglect and abuse, representative newspaper articles from around the country, and a selected professional bibliography.

Also included in the publication is a directory of organizations, services and individuals concerned with aging whose programs may impact on abuse of the elderly. An appendix gives the full text of the Model Adult Protective Service Act. A directory of sources and an author index is included.

Adult Day Health Care Policies and Procedures Manual. Published by On Lok Senior Health Services, 1455 Bush Street, San Francisco, CA 94109. (415) 989-2578. 360 pp. $50 plus $4.00 shipping and handling.

If you are trying to put together an Adult Day Health Care (ADHC) program, this manual provides comprehensive step-by-step policies and procedures, plus over 200 sample/ADHC forms.

Among topics addressed in the Manual are: corporate development steps; physical facility requirements and recommendations; staff qualifications and services; team process — outreach, intake, assessment and discharge; administrative policies and procedures; as well as an ADHC personnel manual.

Ruth Von Behren, Ph.D., On Lok's ADHC Specialist and former Chief of California's state ADHC programs, distills essential ADHC knowledge reaped from top professionals in exemplary ADHC programs and her own extensive knowledge of state requirements to provide information in a practical, step-by-step format.

The Hospice Journal: Physical, Psychosocial, and Pastoral Care of the Dying. Edited by David, M. Dush, Phd. Haworth Press, Inc., 28 East 22 St., New York, NY 10010. $32 for institutions, $38 for libraries and $24 for individuals. (Individuals may deduct the special introductory $7 discount on prepaid orders.) Add postage and handling (per volume: USA $2, Canada/Mexico $7, foreign $10).

The editor of this new journal, Dr. David M. Dush, who is a researcher in the mental health field and a consultant to several hospices, explains that "the journal's aim is to provide a comprehensive . . . multidisciplinary forum for clinical and research articles on all aspects of care for the dying and their families."

The first issue of the journal presents articles on a variety of topics, including "Co-optation and Cooperation between Home Health Agencies and Hospices," "Program Evaluation in Terminal Care," "Toward an Understanding of Life with Cancer," "Hospice Volunteer Programs," "The Prescription to Grieve," and "The Image of the Hospice Chaplain."

The editor welcomes submission of articles. Prospective authors should first request an *Instructions for Authors* brochure from: David M. Dush, Editor, The Hospice Journal, 2620 West Sugnet, Midland, Michigan 48640-2699.

How to Run a Housesitting Business. Available from Jane Poston, Housesitter Security Service, 1708 E. 9th St., Tucson, AZ 85719. (602) 884-8530. 41 pp. $35, including postage.

The author of this publication, Jane Poston, feels that housesitting is one of the fast-growing service businesses in the country and that it is ideally suited to the retired older person. Ms. Poston is 62 and started the Housesitter Security Service in Tucson in 1978.

How to Run a Housesitting Business takes the reader step-by-step through the process of setting up and running the service successfully. Ms. Poston said that the manual represents four years' accumulated experience and, if read carefully, will enable the reader to avoid the mistakes and pitfalls of the formative years.

All aspects of the business are covered, and the *Table of Contents* is divided into two categories: (1) how to begin the business and (2) how to keep it running profitably and smoothly. A sample of some of the subjects covered in the manual are: the need for housesitting; registering a new business; advertising and free publicity; best use of the Yellow Pages; where to find reliable sitters; how to handle clients' calls; matching clients and sitters; how to charge for services; keeping records and accounts; and income tax advantages.

The pages are unbound to allow the reader to make copies of any of the forms, applications and contracts which may be useful. Although the book is copyrighted, permission is given to reproduce the forms and applications, and they can be modified or changed to suit the needs of the readers' community.

Listing of AoA Grantees

(see articles on pp. 22, 25 & 26)

Legal Services Grantees

National Senior Citizens Law Center
1302 18th St., N.W. (Suite 701)
Washington, D.C. 20036
Burton Fretz (202) 887-5280

Commission on Legal Problems of the Elderly
American Bar Association
1800 M Street, N.W.
Washington, D.C. 20036
Nancy Coleman (202) 331-2297

Legal Counsel for the Elderly
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20094
Wayne Morse (202) 662-4933

Center for Social Gerontology
P.O. Box 4488
Ann Arbor, Mich. 43106
Penelope Hommel (313) 662-7680

Housing Grantees

National Fire Protection Assoc.
Batterymarch Park
Quincy, Massachusetts 02269
Mr. O'Neil (617) 770-3000

The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037
Dr. R. Struyk (202) 857-8539

Council of State Housing Agencies
444 N. Capitol St., N.W. Rm. 113
Washington, D.C. 20001
Carl Riedy, Jr. (202) 624-7710

Dept. of Community Affairs
Miami Jewish Home and Hospital
2571 Exec. Center Circle, East
Tallahassee, Florida 32301
Richard Barrett (904) 488-7541

American Association of Retired Persons
Program Development
P.O. Box 19269
Washington, D.C. 20036
Leon Harper (202) 728-4805

Center for the Study of Aging
University of Bridgeport
170 Lafayette Street
Bridgeport, Conn. 06601
Donna Wagner (203) 576-4358

New England Non-Profit Housing Development Corporation
795 Elm Street, Suite 600
Manchester, N.H. 03101
Beth Hughes (603) 627-2383

Cornell University
New York State College of Human Ecology
123 Day Hall, P.O. Box DH
Ithaca, New York 14853-2801
Patricia Pollak (607) 256-3171

Division of Aging
Dept. of Health & Social Services
1901 N. duPont Highway
New Castle, Delaware 19720
Maurice Tippett (302) 421-6791

Colorado Assoc. of Homes and Services for the Aging
2140 South Holly Street
Denver, Colorado 80222
Mary M. Reilly (303) 759-8909

Interfaith Ministries of Nebraska
215 Centennial Mall South
Suite 411
Lincoln, Nebraska 68508-1888
Dr. Mel Luetchens (402) 476-3391

United Way of Dayton
Area Agency on Aging PSA2
184 Salem Avenue
Dayton, Ohio 45405
Jean Farkas (513) 225-3057

West Central Florida Area Agency on Aging, Inc.
8405 N. Himes Ave., Suite 106
Tampa, Florida 33614
Maureen Kelly (813) 933-5945

Housing Bureau for Seniors, Inc.
1010 Wall Street
Ann Arbor, Michigan 48109
Carolyn Hastings (313) 763-0970

East Bronx Council on Aging
2096 Starling Avenue
Bronx, New York 10462
Alberta Orr (212) 409-0050

Alzheimer's Project Grantees

Hillhaven Foundation
1835 Union Ave., Suite 111
Memphis, Tenn. 38104
Dorothy Brodnax, President
(901) 274-8428

Andrus Gerontology Center
Univer. of Southern California
Los Angeles, Calif. 90089-0141
Dr. Neil Cutler (213) 743-6794

N.Y.C. Dept. for the Aging
2 Lafayette Street
New York, N.Y. 10007
Janet Sainer, Commissioner
(212) 577-0829

West Virginia University Gerontology Center
Chestnut Ridge Professional Bldg. Suite 12
Morgantown, W. Va. 26506
Lucille Nahemow (304) 293-2081

University of Chicago
969 E. 60th Street
Chicago, Ill. 60637
Dr. Elsie Pinkston (312) 962-1176

Institute for Policy and Program Development
Andrus Gerontology Center
Univ. of Southern California
University Park MC-0191
Los Angeles, Calif. 90089-0191

Dr. John Pynoos, Director
(213) 743-5981

Tri-City Community Mental Health Center
3901 Indianapolis Blvd.
East Chicago, Ind. 46312
Sandra Appleby (219) 398-7050

Connecticut State Dept. on Aging
175 Main Street
Hartford, Conn. 06106
Alice Gilbert (203) 566-7728

Suncoast Gerontology Center
University of South Florida
12901 North 30th St. MDC Box 50
Tampa, Fla. 33612
Lillian Middleton (813) 974-3100

The Alzheimer's Disease and Related Disorders Assoc. of Eastern Massachusetts
20 Park Plaza, Suite 636
Boston, Mass. 02116
Dr. Joan Hyde (617) 574-9394

University of Kansas College of Health Sciences and Hospital
Long Term Care Gerontology Ctr.
39th St. and Rainbow Blvd.
Kansas City, Kan. 66103
Dr. Linda Redford (913) 588-1210

Bureau of Maine's Elderly
Dept. of Human Services
State House Sta. #11
Augusta, Me. 04333
Patricia A. Riley, Director
(207) 289-2561

Glaucoma

Macular Degeneration

Correction Notice

We would like to call our readers' attention to an error on the poster encouraging eye exams which appeared in the last issue of *Aging* (No. 351). The labels on the two illustrations showing the effects on vision of glaucoma and macular degeneration were reversed. The effects of these two disorders are correctly labelled in the photos above. We also apologize for a less serious but certainly "prominate" spelling error which appeared on the back of the eye exam poster.

THE NUMBERS GAME

Discovering the Older Market

by Donald Fowles*

The American business community has often been accused of ignoring the older consumer. There is some truth in the charge. As Martha Farnsworth Riche, associate editor of *American Demographics*, has stated, ". . . at age 65 it was over: the retirement party put an end to the consuming life as well as the producing life."

But as our population ages, our attitudes about age are changing. The widespread view in the past that the older population could be characterized by poor health and low income is being replaced with a more realistic view of the diversity of this age group.

One example of a growing interest in the older market by the business community is a group of articles over the last year in *American Demographics*, a monthly journal of demographic research written primarily for the business community (American Demographics, Inc., P.O. Box 68, Ithaca, NY 14851). In 1983, this journal had only one article on the older population; in 1984, two. In 1985 (and the first issue for 1986), this journal had four feature articles on the older market and an overview of the demographic characteristics of the "oldest old" (persons 85 years and over).

The first feature article, "Inside the Mature Market," appeared in the March 1985 issue. The author, William Lazer, a professor of business administration at Florida Atlantic University, states, "Too many businesses think the older market is a poor market, missing opportunities to explore an almost untouched landscape of 51 million consumers [55 years or older]. . . . It is too large and profitable a market to ignore."

Lazer divides the older or "mature" population into four market segments: "older" (55-64), "elderly" (65-74), "aged" (75-84), and "very old" (85+). He points out that the two segments under 75 years of age are similar to younger age groups in past generations and that they represent markets for products and services related to personal appearance (diet, exercise, personal care, health, clothing), lifestyle (travel, leisure activities), and services (restaurants, home maintenance).

People 75 to 84 years old "fit the senior citizen image much better" than those under 75. This age group is beginning to experience serious health problems and mobility limitations, and constitutes a market for health care services and special care facilities.

People 85 years and older are the "true elderly of our society," according to Lazer, but the "needs of this group are not well understood, because this market has never before reached a size significant enough for marketers to investigate closely."

Lazer notes that "more than one-third of all households with discretionary income are headed by mature consumers—those aged 55 and older," and that the "spending power of the mature market may be one of the best-kept secrets left in the age of demographic scrutiny."

Mature married couples generally own their homes outright, are free of child-rearing responsibilities, and are willing to spend money on themselves. However, people in this age group who live alone have lower incomes than married couples and are less willing to indulge themselves, but are often willing to spend on children and grandchildren. Lazer believes there "is opportunity here for marketers who can convince mature consumers that they can afford to spend on themselves."

In "The Home Health Care Market" (April 1985 issue), Brad Edmondson, a free-lance writer, stresses that people "aged 85 and over will grow 83 percent by the turn of the century, from 2.7 million in 1985 to 4.9 million in 2000." Because of this growth, "an increasing share of the elderly will require professional assistance with homemaking, personal hygiene, and health care."

Edmondson describes the phenomenal growth of the home health care market in recent years and the recent changes in Medicare and Medicaid regulations to provide coverage for this type of care. The industry may remain fluid because the issue of health care costs will likely be in the forefront for decades, subject to changes in law and regulation.

Edmondson provides brief market histories and projections for several home health technologies: kidney dialysis, home infusion (intravenous) therapy, respiratory therapy, disposable diapers for adults ("the largest single category" of adult home care medical products), and home nursing and health aide services.

In "The Nursing Home Dilemma"

*Mr. Fowles is a statistician for the Office of Planning, Evaluation and Dissemination in the Administration on Aging.

(October 1985 issue), Martha Farnsworth Riche states that the nation faces a dilemma because of the increasing demand for nursing home care, an expensive service which is not well-covered by private or public insurance.

Riche indicates that we will need to build from 300 to 600 new 100-bed nursing homes each year to keep up with projected demand through the year 2003 if current rates of nursing home utilization continue. At the same time, "Medicaid cost-containment pressures are forcing states to restrict nursing-home construction."

According to Riche, four out of five members of the American Association of Retired Persons incorrectly believe that Medicare covers nursing home care. In fact, Medicare only pays for a maximum of 100 days of such care, not all types of stays are covered, and Medicare may not cover all costs.

At an average yearly cost for nursing home care of about $25,000, people requiring long-term nursing or custodial care quickly exhaust their resources and must turn to Medicaid, the primary public program for paying the costs of such care. The need for alternative financing mechanisms is clear.

Riche discusses some pioneer efforts to provide private insurance for long-term care. According to the American Health Care Association, two problems could hinder the development of such insurance: developing the actuarial basis necessary for an affordable yet profitable policy, and marketing a policy to people who think they already have such coverage.

At the same time, for-profit nursing home chains, an increasingly important segment of this industry, are attempting to upgrade the appearance of homes, improve the level of care, and add amenities in order to attract a clientele that does not rely on government programs for payment but can afford to pay its own way. Industry observers acknowledge, however, that the majority of nursing home residents will not be able to pay for extended stays in nursing homes.

In another article, "Retirement's Lifestyle Pioneers" (January 1986 issue), Riche moves from nursing homes to a discussion of organized living arrangements of the non-institutionalized elderly. She describes past and future developments in three kinds of arrangements: retirement communities, congregate care, and continuing care. However, she notes that most older people want to remain independent and that they do not, on average, want to move away from their homes, families, or communities after retirement.

Although the movement toward developing independent living arrangements in retirement communities, particularly in the Sun Belt, has achieved some success since it began in the 1950's, it has not lived up to early expectations. According to Riche, current trends indicate an interest by developers in locating such projects outside the Sun Belt, in or near the communities where the elderly are living before retirement.

Congregate-care facilities provide a higher level of care than that found in retirement communities. These facilities generally provide a mix of services within an apartment- or dormitory-style complex and are the "developers' response to the needs of the older elderly, particularly those who don't need nursing care but do need help in living." Although congregate-care facilities are not a new idea, Riche cites an estimate that only five percent of the "affluent elderly market" has been penetrated and that this market will "more than double over the next five years."

Continuing-care communities are somewhat similar to congregate-care facilities, but add guaranteed health care. Although such communities are expensive (an initial entry fee from $20,000 to $200,000 plus monthly payments), Riche indicates that this market is also largely untapped. These communities are expensive to develop and require "careful planning and specialized management because they combine several businesses: real estate development, food services, leisure activities, health care, and insurance."

Although nonprofit organizations and hospitals have moved into this field, Riche cites John Dillon, administrator of a continuing-care community in California, as one who believes that hotel chains are in the best position to dominate this market in the future. The Marriott firm evaluated several health care industries and selected continuing care as its best choice to exploit with its experience in food service and hotel management.

Riche recognizes that many elderly do not desire or cannot afford to live in any of these organized, age-segregated forms of living arrangements. Many local communities are providing services—congregate or home-delivered meals, home health care, and others—that assist older people to live independently in their homes.

In the short run, housing developments for the elderly will have to include some form of health care because of the growing numbers of the oldest old. According to Riche, the long run is less clear. The "baby boom will be the best-educated and healthiest generation of elderly in history," presenting a real opportunity for the housing marketer in the future. With their IRA's to supplement their retirement income, will this generation, "which has blazed so many lifestyle paths, blaze one in retirement too?"

These four articles illustrate the growing recognition by the business sector of the marketing opportunities presented by the growth of the older population. These opportunities often require expensive technologies and careful planning. However, marketers must remember that the elderly population is not uniformly affluent, just as it is not uniformly poor. Older Americans are as diverse in their interests and circumstances as the rest of the American population.

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Health Promotio
Older Americans Month

Aging

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The White Crane:
Symbol of Long Life and Happiness

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The Commissioner's Corner

Carol Fraser Fisk

Five years ago, it was highly unlikely that you would see a 65- or 70-year old man jogging through the park or a suburban neighborhood. Today, it is not so extraordinary, and although his pace may be slower than the younger joggers, his appearance will be as regular—at 9 or 10 o'clock in the morning sun.

The addition of senior citizens to the swelling ranks of Americans who are rediscovering the joys and benefits of physical exercise marks a rather dramatic change in our perception of old age. Over the past decade, health experts and gerontologists have been reeducating the public to understand that serious physical decline is not necessarily a normal part of aging, but is frequently the result of poor health habits and underused physical capacities.

Because older Americans had been programmed to believe that getting older meant giving up the physical activities of youth and the middle years, too many senior citizens surrendered to the easy chair to become spectators rather than participants in the active life. But in the past five years, organizations in the field of health and aging have greatly altered our ideas about aging, and these changed assumptions are leading older citizens to begin thinking about how they can protect and maintain health in order to extend active and independent lives.

This new challenge to our older population is embodied in the overall theme selected for the next several years for Older Americans Month, which is "Plan on Living the Rest of Your Life." The special subtheme for 1986 is "Have Your Health and Have Everything," because, indeed, good health gives each of us the foundation on which to build happy and productive lives.

Older Americans Month is an opportunity not only to focus attention on the experience and talents of the elderly but also to educate ourselves about the needs and challenges posed by this rapidly increasing part of our population. Since the turn of the century, nearly 25 years have been added to the average life span, and by the year 2050, one in five citizens will be 65 or older.

Without a relatively healthy older population, our health care resources will be impossibly burdened. Promoting good health among older Americans and insuring a high quality of health care at a reasonable cost for those who need it is a challenge that requires us to see beyond the "here and now." We need to identify intelligent approaches to prevent as well as to solve health care problems that could become overwhelming as the population ages.

We must recognize first that each of us is the most important player in helping to ensure our own good health. Every American must be encouraged early in life to develop patterns of regular exercise, practice good dietary habits, and adopt an overall life style that promotes good health. These patterns, if developed early, will help to provide a continuity of good health as we age.

But for those in the middle and later years, we must also recognize that changing long-established life styles—even for those who have neglected their own care—can still lead to substantially improved health. This can be accomplished through understanding and improving nutrition; using medications wisely; engaging in exercise appropriate to one's age and physical condition; taking measures to prevent accidents; getting regular health checkups; and stopping extremely harmful habits, such as smoking. We must realize that attempting to make these changes in our lives—some of which are extremely difficult—may be very significant in delaying or reducing some chronic conditions.

Finally, as the population ages, we must continue to explore with the private sector new ways to assist the frail and the homebound elderly, with special attention to families who provide nearly 80 percent of the non-medical care needed by older Americans. We must find new and improved ways to support in-home and community-based care in order to keep families intact and preserve the independence of our oldest citizens. The Administration on Aging is continuing to support research, demonstration and training programs to increase our knowledge of ways to improve health and other services for the vulnerable old and supportive services for their caregivers.

AoA and the U.S. Public Health Service are also engaged in a long-term health promotion initiative for all older Americans—one that parallels similar efforts by such groups as the National Council on the Aging and the American Association of Retired Persons. Supporting the AoA/PHS health promotion initiative throughout the country are State and Area Agencies on Aging which are providing information and assistance to both the well and the frail elderly to help them maintain or enhance their health and independence. These agencies are also directing new attention to the health needs of family caregivers. The network on aging certainly deserves special commendation for its important contributions during the past 20 years in health care education and services.

Although important strides have been made in raising the nation's awareness of the benefits of good health habits and of the health care needs of the elderly and their families, much work remains to be done. The real reward for all agencies and organizations engaged in health promotion will occur when each person, young and old, assumes a more active role in protecting and maintaining their own health.

We are not all destined to run races in our 70's or even to jog daily through the park, but these older athletes, in daring to test their physical capacities, are leading the way for millions of Americans to change their thinking about physical and other capabilities in the later years.

For most older Americans, taking the first step in using physical capabilities may simply mean introducing a brisk 20-minute walk into their daily routine. All older adults, however, are advised to consult with their physician about what exercise is best for them before embarking on a new program of physical fitness.

The poet Robert Burns once said that "health is the first wealth." With it, you have the foundation for everything else in life.

Aging

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration on Aging

Chicago's White Crane Senior Health Center, p. 8

On the Cover

Traditionally a symbol of long life in Asia, the beautiful Japanese Crane stands nearly five feet tall, yet is amazingly graceful in flight. At times, uncannily human, cranes have also come to symbolize marital fidelity and love because they pair for life, share domestic tasks equally and pamper their young. Although their estimated life in the wild, with all its hazards, is 30 to 50 years, the Japanese imagined that cranes lived a thousand years. The ancient Chinese classics also celebrated the bird's endurance, describing the crane as the bird-chariot of the immortal sages, who were transported on its wings.

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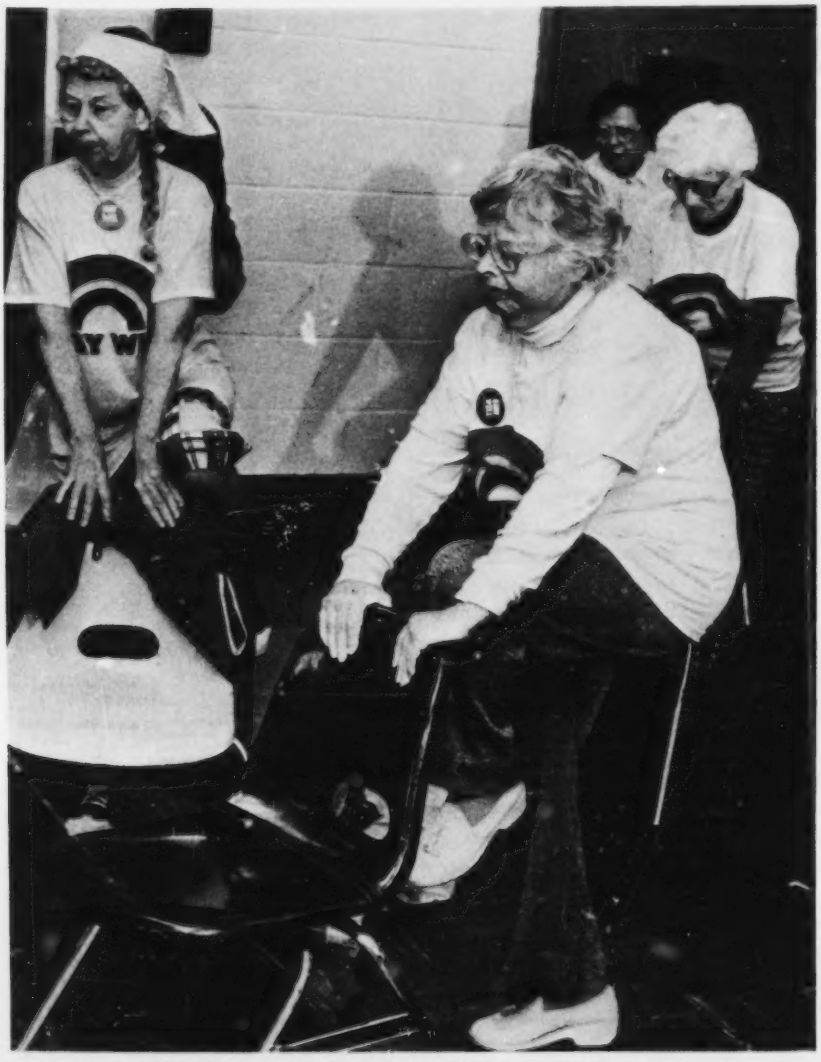
"Project Stay Well" Does Well in New York City

by Fran Freedman and Stan Friedmann

Winner of AoA Project Health Award



Project Stay Well participants limber up at specially developed non-aerobic exercise classes led by trained older adult volunteer leaders.

In upper Manhattan, older adults work up an appetite for their lunchtime meal each day by exercising together at their Harlem senior center. In Brooklyn, a 73-year-old woman has stopped smoking and now participates in regularly scheduled stress management classes at her senior center. In Queens and the Bronx, older adults have joined walking clubs.

What has "turned on" more than 4,000 New York City older adults to more active, healthier life styles? PROJECT STAY WELL. A collaborative effort of the New York City Department for the Aging and the New York Academy of Medicine, the health promotion/wellness program was launched two years ago with the goal of developing and expanding health promotion programs for New York City's elderly through the senior center network.

A unique public-private partnership, PROJECT STAY WELL is supported by private funding sources, including the Florence V. Burden Foundation, Exxon Corporation, Morgan Guaranty Bank, The New York Community Trust, and The Uris Brothers Foundation, Inc.

Not only has the health promotion program educated older people about ways to pursue a healthier life, it has also utilized the new "converts" as volunteers who lead activities to help other adults take charge of their own health and well-being.

A Basic Health Curriculum

PROJECT STAY WELL has taken a threefold approach to health promotion programming by: providing a formal 12-session educational curriculum; setting up a volunteer training program; and establishing and

Fran Freedman is Director of the Health Services Unit in the New York City Department for the Aging and Stan Friedmann is Director of Project Stay Well.

supervising volunteer-led health promotion activities.

The first component, the 12-session health education curriculum is coordinated by PROJECT STAY WELL staff and presented twice a week for six weeks to groups of 35 pre-registered older adults. Each 2½-hour session includes a lecture and discussion, a non-aerobic exercise lesson, and a segment on stress management techniques.

The wide range of subjects covered in the lectures has included coping with chronic conditions, sexuality after 60, dealing with grief and loss, maintaining vision and hearing, safety in the home, medication management, nutrition, and communicating with health care professionals. The sessions are conducted by professionals from voluntary health agencies and local hospitals who provide their services on a *pro bono* basis, contributing staff expertise and materials to the program.

The second component of the project, the volunteer training program, recruits "graduates" of the STAY WELL education curriculum and trains them in skills needed to conduct health promotion programs for their peers at senior centers. Participants in this six-session training program attend classes on group dynamics and leadership skills, followed by specialized training seminars which prepare the volunteers as exercise instructors, stress management leaders, health forum coordinators and walking club leaders. Training classes are led by STAY WELL staff and representatives from voluntary health agencies.

The volunteers are then assigned to conduct health promotion activities on a weekly basis. They also recruit new participants, keep records of activities, and work with senior center staff. Currently, 60 older adult volunteers are providing 57 health promotion programs at 24 senior centers in 8 communities.

The third component of the project is insuring the success of the health promotion activities led by the volunteers. The STAY WELL staff conducts monthly in-service training sessions for the volunteer leaders in each community and carries out an on-site observation of leaders and activities, which is followed by meetings with each of the leaders.

Response Beyond Expectations

Since the project started in 1984, more than 4,000 older adults have participated in health promotion classes and activities at the 24 senior centers. Thousands of other older citizens have benefited from community-wide health programs and special events that some of the older volunteers have conducted in addition to leading classes at the centers.

It is clear the PROJECT STAY WELL has generated a response from older New Yorkers far beyond the expectations of the program's planners. Older citizens have demonstrated a willingness and enthusiasm to learn new health management skills and to become actively engaged in a health-related activities. They have shown they are especially interested in sharing their new knowledge and expertise with their peers, and are eager to acquire leadership skills as volunteers.

PROJECT STAY WELL has demonstrated, too, that the role of the senior center can be expanded to include health promotion activities. In the past, health promotion and wellness programs were not generally included in regularly scheduled senior center activities on an ongoing basis. The commitment and interest of the senior center staff has been critical in making health promotion a regular and important part of the senior center schedule.

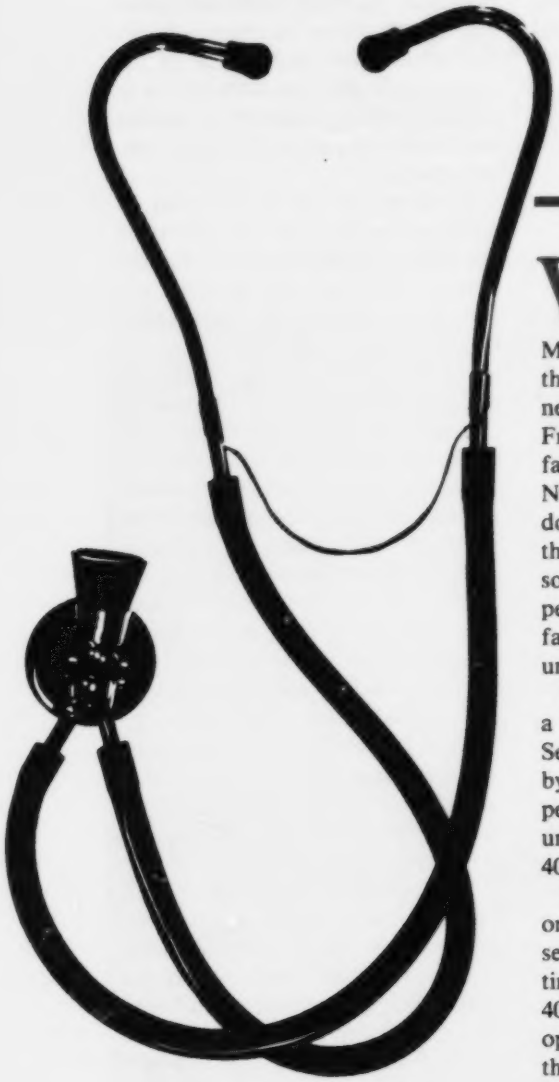
It is not only the involvement of volunteer leaders that has obviated the need for paid instructors, but the substantial investment of time and energy by health care providers. Commitments from a group of 75 health care providers resulted in the *pro bono* delivery of 82 curriculum presentations and approximately 65 additional health promotion activities over the past two years. Every health provider that became affiliated with the STAY WELL program conducted one of the health curriculum lectures, providing educational materials, staff and expertise at the senior center engaged in the health program. And in the process of working with city senior centers, the health care providers have become more aware of issues relating to aging and the expanded role their organizations can play in addressing the special needs of the elderly.

Thus, PROJECT STAY WELL has been able to create a cost-effective approach to bringing health programs to the elderly which not only educate but train them in health promoting activities. Most significantly, these volunteer-led activities have produced a substantial "ripple effect" as more and more older people are recruited, trained and involved.

For more information or for written materials on PROJECT STAY WELL, call the New York City Department for the Aging (212) 577-7345, or write to: The Health Unit, New York City Department for the Aging, 280 Broadway, New York, N.Y. 10007.

Retired M.D.'s— A Hidden Goldmine for the Elderly

by Dismas McAuliffe



Retired volunteer medical personnel run Florida clinics

When was the last time you went to a physicians office and had a 40-minute visit? More likely you spent 40-minutes in the waiting room. But if you were a new patient entering one of the Senior Friendship Centers health service facilities in Sarasota, Fort Myers, or Naples, Florida, your visit with the doctor *would be* 40 minutes. Why is the medical care at these health clinics so different from what we usually experience? Well, there are a number of factors that contribute to their uniqueness.

Perhaps the most unusual aspect of a Senior Friendship Centers Health Service is that it is staffed completely by retired doctors, nurses, and office personnel. It is the age of these volunteers that is responsible for the 40-minute visit.

Frequently, in addition to the ache or pain for which the older person is seeking treatment, there are sometimes deeper hurts. By allowing a 40-minute visit, the elderly have an opportunity to talk about the things that are really bothering them—the isolation and loneliness they are experiencing in their lives. The retired physicians who are also seniors themselves can empathize with these feelings and thus are able to prescribe more than the traditional "two aspirins."

Mr. Dismas McAuliffe is Director of Information and Director of Volunteer Services for Senior Friendship Centers in Sarasota, Florida.

The Restless Doctor

In 1977, the late Dr. Irwin Portner at age 71 had retired to Sarasota from his private practice in Boston because he had been suffering from Legionnaires' disease. However, having recovered his health, he was restless to get back into medicine once again. One day when he was complaining to someone of this, the friend remarked, "Why don't you get in touch with Brother Geenen over at Senior Friendship Centers. He'll find something for you to do."

Brother William Geenen is the Holy Cross Brother from Notre Dame, Indiana, who in 1973 founded Senior Friendship Centers with the goal of enabling older persons to live the later years of life in dignity and peace. Started simply as "a place for coming together" for people 60 years of age and over regardless of race or creed, Senior Friendship Centers has grown from a single location to 24 sites in Sarasota County providing 15 different services to elderly persons.

Remembering the day when Dr. Portner called him to make an appointment, Brother Geenen says, "Not only was it a reverse situation with a doctor asking for an appointment, but it was an answer to my prayers."

A survey made several years earlier revealed there were approximately 5,000 older persons in Sarasota County who either had not been to see a doctor, or had seen one only once, in the previous year. Yet the

Dismas McAuliffe

Regina Cohen, 84, a patient at Senior Friendship Centers Health Service in Sarasota, seems pleased at what Dr. Joanna Rodziewicz is telling her. Many of the patients cannot afford private medical care but are not poor enough to qualify for public health department programs.

survey indicated that these people needed more medical attention but they were not poor enough to be eligible for the County Health Department nor sufficiently well-off to afford private medical care. They were the people who were "falling in the cracks." It didn't take Brother Geenen long to convince Dr. Portner that he could certainly use the services the doctor had to offer.

Dr. Portner's first task was to obtain the approval of the local Health Department and the endorsement of the County Medical Society. He then recruited two other retired physicians, Dr. Gilbert Dorrance and Dr. Stanley Kornblum, who were willing to work with him in providing care for the medically underserved elderly.

Florida differs from other states in that it grants limited licenses to out-of-state physicians as long as they are donating their services to a non-profit organization such as Senior Friendship Centers. When a Health Service physician sees a patient who requires surgery or hospitalization, the patient is referred to one of a number of practicing physicians in town who will accept new patients.

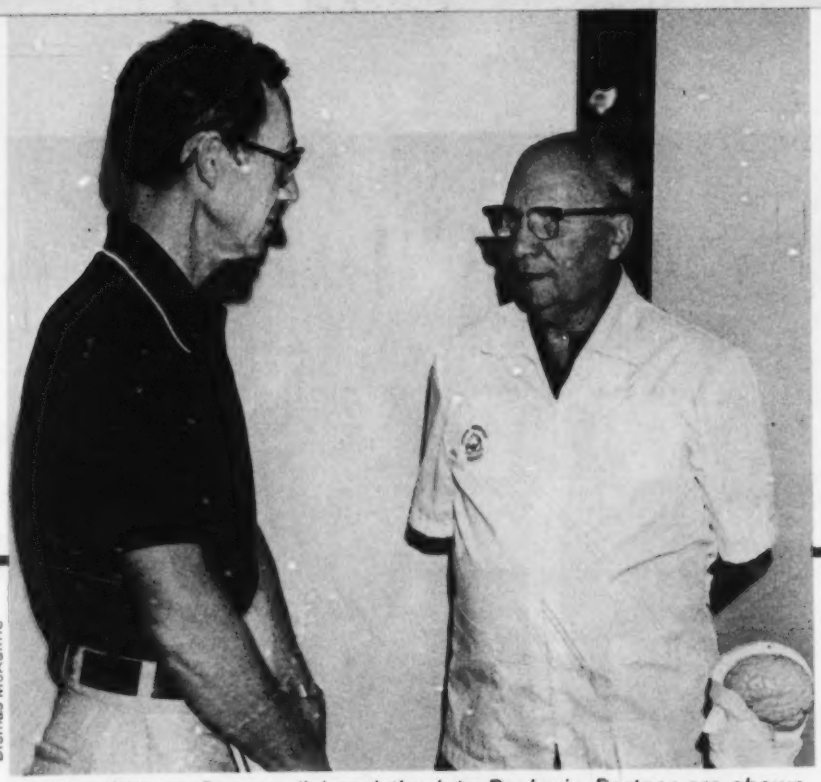
It didn't take long for this new service for the elderly to catch on, and within a short time, the Health Service had outgrown the small office it occupied in a multi-purpose center. Brother Geenen then obtained another building which was remodeled into a modern health clinic with five fully equipped examining rooms, a small laboratory, an ENT room for dental, opthamology, and ear, nose and throat service, a nurses' station, medical records room, director's office, and a small medical library. The office is run on a professional basis with a rotating team of secretaries making appointments and then calling patients to remind them the day prior to the appointment.

The Senior Friendship Centers provides transportation to and from the Health Service for those patients who have no other alternative. The transportation vans are equipped with hydraulic lifts to transport people needing wheelchairs.

Detecting Serious Illness

The Health Service serves not only the physical needs of the patients but very often assists in helping them to take positive steps to change their lives. A case of a 62-year-old woman who came to the Health Service for a physical exam because she was "not feeling well" led to almost daily assistance from a Senior Friendship counselor to straighten up an unbearable life.

The physician, after spending some time talking to the patient, realized



Dismas McAuliffe

Brother William Geenen (L.) and the late Dr. Irwin Portner are shown conferring shortly after they opened the all-volunteer health service.

Beyond the ache or pain for which the olde person is seeking treatment, there are sometimes deeper hurts.

this lady was deeply disturbed and suffering from anorexia and malnutrition. An appointment was made with the Senior Friendship Centers psychiatrist. The extent of her mental and personal problems was slowly uncovered. The lady was living in terror of herself in many ways—she spoke of suicide, murder, and monsters, and more. The counselor visited and talked with her daily and took her to Candlelight Dining (another service of Senior Friendship Centers). She soon trusted the senior organization enough that she was willing to be admitted to the local psychiatric facility for extensive treatment. From there she entered an adult congregate living facility where it is hoped she will resume a normal living pattern. This was an intelligent woman who needed guidance which would not have been forthcoming if the initial visit to a physician had lasted only long enough to treat the "feeling unwell" symptoms.

A few weeks ago a belligerent man came into the Health Service and spoke angrily to the secretary when she asked for his name and appointment time. He so frightened her that she said to her supervisor, "I'm not even going to ask him to sign a Medicare form when he leaves because he might bite my head off." (The Health Services is a recognized Medicare provider.) But when it was his time to see the doctor, the doctor sat and talked to him for 40 minutes. The patient then left the office wearing a big grin. He said to the astonished secretary, "I never had a doctor spend so much time talking to me." He also saw the dentist and came out of that appointment smiling even more. He left the building with the feeling that he had found a friend at Senior Friendship Centers, where the motto is "People Helping People."

Last week a woman had an appointment with the ENT specialist because she had been gradually getting hoarse over the last few weeks. Upon examination of the frail elderly woman, the throat specialist found a small growth in her throat. Referral was made to a local physician who performed a laryngectomy to remove a cancerous growth and save the patient from an untimely death. Since this patient was indigent, she probably would not have gone to a local doctor without Senior Friendship Centers' arranging the appointment and setting up a special agreement with the specialist to accept the Medicare payment. Since she returned home from the hospital, Senior Friendship Centers continues to assist her with a homemaker.

Dr. Portner used to tell the story about one of his first patients—a lady with multiple symptoms that he suspected to be a gastric cancer. She was referred to a local gastroenterologist and surgery was performed to remove the malignancy. Another life was saved.

Time To Counsel and Console

The staff of the Health Service believe that in addition to routine medical interventions, the most important part of their service is the time given to counsel, console, and connect patients to the proper resources. It takes time, energy and lots of questions, but the staff feels that the satisfaction derived at seeing a person with a new grasp on life is worth the effort.

In addition to general practice, the staff of retired doctors includes physicians who had been specialists while in private practice. As a result the Health Service can boast of specialties in allergies, cardiology, dentistry, ear, nose and throat, gynecology, orthopedics, ophthalmology, podiatry, psychiatry, pulmonary respiratory, rehabilitative medicine, urology, and vascular consulting. The Health Service staff also includes three retired social workers.

Another distinctive aspect of the Health Service is that a referral is made for each new patient so that a counselor visits the person at home to

Dismas McAuliffe

Volunteer David Field, D.D.S., gives an oral exam to one of the patients at Senior Friendship Centers.

Dismas McAuliffe

Jessie Bole sees Dr. Egon Fisher.

acquaint that person with the other services that are available from Senior Friendship Centers. These services may include homemaker assistance, which enables older persons to continue living independently even when their frailty may prevent them from performing the usual household chores.

Operating on a continuum of service theory, the Senior Friendship Centers tries to meet whatever needs a senior citizen has that are not being met by the local community. Using school cafeterias, church halls, etc., the organization provides a hot meal five evenings a week in its Candlelight Dining program. This enables the isolated elderly to enjoy a nutritious meal in the company of others.

There is strong community support for Senior Friendship Centers. When it needed more room to accommodate the frail elderly in its adult day care facility, known as the "Living Room," the City of Sarasota made two acres of park land available for that purpose. Brother Geenen then demonstrated that the city's confidence in Senior Friendship Centers was well placed by designing an adult day care facility that serves as a national model.

The "People Helping People" team of Senior Friendship Centers is not limiting its assistance to senior citizens of Sarasota County. Brother Geenen is very much aware that there are other places in the country that need organizations similar to the one in Sarasota. Brother Geenen says he is willing to supply organization techniques if there is someone willing to pick up the challenge.

Brother Geenen can be reached at Senior Friendship Centers, 1820 Alderman Street Sarasota, Florida 33577. (813) 955-2122

White Crane Senior Health

A Senior Caucus and a hospital create a health center in Chicago

by Robert Skeist, R.N., M.S.

On a beautiful Spring morning in Chicago, a group of people in their 60's, 70's and 80's gather in Lincoln Park at a grassy area overlooking a lagoon. They greet each other, go through a series of slow and gentle warm-ups, then move in unison in what looks like a cross between slow-motion karate and ballet. "Now," says the instructor, 72-year-old Shizu Lofton, "the white crane spreads its wings and flies forward." Each participant moves forward, weight gradually shifting from left leg to right leg and back, arms floating up and down as though moved by the May breeze.

We are watching a class of Tai Chi for Elders, an adaptation of an ancient Chinese approach to staying healthy. The white crane movement improves strength and balance for walking, and it is rich in imagery. For throughout Asia, the white crane—a beautiful bird, graceful in flight—has traditionally been a symbol of long life, health, happiness, and peace. As East meets Mid-West, this elegant bird now shares its imagery and its name with a unique effort dedicated to promoting the good health of seniors. In the heart of Chicago's Lakeview community, home to the city's largest concentration of older people, the White Crane Senior Health Center is spreading its wings.

Dream of Health Activists

The center's origins are as unusual as its name. In an era when decisions affecting the health care of older Americans are made more and more by for-profit corporations, hospital marketers, and government agencies, White Crane grew out of the dreams and determination of a grassroots community organization. The Senior Caucus of Jane Addams Center, led by 75-year-old Ruth Shriman, was dismayed by the tendency of many health care professionals to see old age as synonymous with disease, by the rising consumer costs and serious limitations in coverage of Medicare, and by the seeming indifference of many health care institutions to the opinions of seniors in the community. Ruth Shriman recalls how her group channeled its frustration positively, holding a "dream meeting, where we talked about and listed all the things that we seniors would want in an ideal 'wellness'/health center. The result was a model that would be affordable, accessible, and available to all seniors. It would be controlled by the community, stress prevention and education, and be staffed by people with geriatric training and/or expertise."

Senior Caucus members toured clinics and community centers all over Chicago, made phone surveys of services offered at area hospitals, and met with medical and health promotion experts. Simultaneously, they drafted a survey to reach out to their peers in the surrounding neighborhoods. Soon word of these older health care activists reached the executive conference rooms of a nearby hospital, Illinois Masonic Medical Center (IMMC).

Administrators at IMMC were grappling with how to reach out effectively to healthy seniors in its community. According to the Administrator of Ambulatory Care Suzanne Sullivan, "three things drew us to the seniors group. First, IMMC already had many pieces of the geriatric care puzzle in place, from our Warren Barr Pavilion nursing home to home health and hospice, from a hospital affiliated with a medical school to ambulatory care programs such as eye care, dental care, and counseling. Second, we had been successful with another innovation, our Women's

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Robert Skeist is Director of the White Crane Senior Health Center in Chicago and author of the book, To Your Good Health, A Practical Guide for Older Americans, Their Families and Friends.

Center Spreads Its Wings

Tai Chi: Shizu Loften, age 72, is the instructor at the health center for classes in this gentle Chinese exercise.

Health Resources Center, providing health care services for young and mid-life women in a homelike facility staffed completely by women. Third, the Senior Caucus had impressive ideas, numbers, and determination. We saw an opportunity for community service, and we saw a good investment."

The relationship between the seniors and the hospital developed in stages. They cooperated on the community survey, with the seniors conducting face-to-face interviews with 300 older people in the community and the hospital computerizing the results. The results were encouraging to both parties: seniors in the community liked the neighborhood-based, staying healthy model. IMMC projected a potential consumer base of 13,000. Through negotiations, the partnership was formalized. Power was vested in a 15-member Board of Directors, composed of five members of the Senior Caucus, five representatives of IMMC, and five community leaders. The community representatives selected by the seniors and the hospital indicate the breadth of community interest in creating this new center: they come from the Japanese American Service Committee, the Jewish Community Centers, Lake-

view Central Business Association, Wellington Avenue Congregational Church and the Jane Addams Center/Hull House.

From Primary Care to Tai Chi

By May, 1985, the first staff were hired. The new center's site had not been selected, let alone renovated and opened, but White Crane programs took off. As of May, 1986, the following programs operate out of space at IMMC, the Jane Addams Center, and several community centers:

Primary medical care. Steven Lorsch, M.D., an internist with advanced training in geriatric medicine and Cindy Nissen, R.N., M.S.N., Clinical Nurse Specialist in Gerontology, have hung up their shingle. They place great emphasis on helping seniors understand their conditions, their treatment options, and what they can do to help themselves stay healthy. Treatment plans may include wise use of medications and occasional hospitalization at IMMC, as well as support groups and exercise classes.

Health screenings, education, and support groups. Both seniors from the general community and White Crane patients are offered screenings and referral for high blood pressure, eye problems, foot problems, and more. Ms. Nissen has developed 4-session support groups for seniors coping with arthritis, high blood pressure, and stress. White Crane staff and other IMMC professionals offer educational programs on topics ranging from coping with urinary problems to preventing cancer to protecting patients' rights.

Eli Goto, a Nisei (first generation Japanese American) teaches Yetta Marcus and Dolores Spetyla how to fold white cranes, using origami paper.

Seniors Massage Project. In collaboration with the Chicago School of Massage Therapy, White Crane sponsors a series of classes to teach seniors practical, safe, and enjoyable techniques of self- and partner-massage. Volunteers from this project also soothe tensed shoulders of seniors at community centers.

Tai Chi for Elders. Developed over the past seven years by staff now at White Crane, this adaptation of the gentle Chinese exercise is taught at 10 sites to 300 seniors. White Crane offers three levels of classes plus a monthly Tai Chi Club meeting, featuring a guest speaker and lunch in the IMMC cafeteria.

In its first year after hiring staff, White Crane has provided some form of direct service to over 2,000 area seniors, has led sessions at several national conferences of the American Association of Retired Persons and the American Hospital Association, and has done the behind-the-scenes work involved with choosing, designing, and equipping its site. By July, 1986, White Crane Senior Health Center will open its doors in a space created from three adjoining storefronts in the heart of the Lakeview community. This new home will bring three new strengths to White Crane:

A comprehensive, community-based program to help seniors stay healthy. Existing services will be supplemented by podiatry, ophthalmology, and other clinical specialties, financial counseling and assistance in filing forms, audiology services, community information and referral, nutrition and cooking classes, expanded exercise programs, cultural and social gatherings, and a laypersons's health and medical library. Participants will also have access to the full range of IMMC medical services and Senior Caucus community outreach projects.

A facility designed with seniors in mind. At considerable cost in staff time, construction, and equipment, the White Crane Senior Health Center facility will include six medical exam rooms, one designed for specialty procedures or family conferences, and each with a hydraulic lift exam table; wheelchair accessibility and an audio loop system for the hard-of-hearing; carpeting, color scheme, and furniture chosen for comfort, aesthetics, and safety; and excellent space and supplies for cooking, exercise, and massage.

Ahhh! Matt Guarino enjoys instruction in massage therapy from Berniw Wolf, R.N., Ms.T.

Active involvement with the community. According to Tom Tunney, owner of Ann Sather's Restaurant across the street from the new Center, "White Crane will bring a lot of life and business to this area, and we in the business community should give them a real welcome." Tunney is helping to make business owners more aware of the health care and consumer needs of seniors in his neighborhood and is hosting a benefit dinner for White Crane's Affordability Fund. Benefit organizers hope to raise $5,000 from the community to be matched 4 to 1 by IMMC, generating $25,000 for outpatient medical services for seniors with insufficient medical funds. The keynote speaker at the Affordability Fund benefit is Mayor Harold Washington.

If all this sounds like a departure from medical business as usual, it is. White Crane gets its power to fly from the unusual collaboration of hospital and community, and from seniors with unusual vision. As Shizu Lofton says, "We don't buy the myth that old age is a time to be endured with a stiff upper lip, teeth gritted against pain, neglect, frailty, and pity. Old age is only another stage in the life that began when we were infants. We can still make it a time for reaching out and touching life, but with the wisdom of our years."

For further information, write Robert Skeist, Director, White Crane Senior Health Center, 906 W. Belmont Avenue, Chicago, IL 60657.

Frail Elderly

by Jane Heald

An immigrant from Greece, Angela was a very independent woman. Despite disability from a crippled hip, she had used her natural talent for business after her husband died in the depression to raise two children on her own. After her children were grown and married, she moved to an apartment where she managed very well, even into her 70's, with grocery shopping and other help from her middle-aged daughter, Theresa.

Finally at age 78, Angela accepted her daughter's invitation to combine households. She was very good company. Both Theresa and her husband, Bill, really enjoyed having her there. Not until her 92nd birthday did she admit, "I think I'm beginning to get old."

But then after she fell and broke her arm, she couldn't use her walker any more, and because of her bad hip, she wasn't comfortable for very long in any one position. So all day, Theresa was lifting her mother—from bed . . . to wheelchair . . . to sofa . . . to wheelchair . . . and back to bed. When her mother got a bladder infection, the visiting nurse taught Theresa about catheters. Then Theresa developed an ache in her shoulder that wouldn't go away, and the doctor told her she mustn't lift her mother any more. So Theresa's husband, who had taken another job after retirement, quit work to help out. Shortly afterward, his hernia began to act up.

An acute health crisis can bring out the best in a family. Most of us don't hesitate when we're summoned to a bedside. However, a non-crisis can produce enormous strain. When problems are debilitating, but not life-threatening, everyone in the family is challenged to evolve a new life style. Balancing the conflicting needs of different family members requires thought and courage. However, people *can* learn to provide appropriate assistance to their frail relatives and, at the same time, attain personal harmony.

When an elderly person has the grace to ask for help and receive it thankfully—especially when he or she is willing to receive it from a variety of sources—a family's task is much easier. In the same way, when a caregiver has the grace to recognize that he or she needs help and goes looking for it, everyone benefits. Do-it-yourself determination that results in exhaustion and frustration is not kind. Instead, it can sabotage the one great source of strength the infirm have left—their healthy, loving relationships with the family.

The National Support Center for Families of the Aging in Swarthmore, Pennsylvania was incorporated in 1981 as a nonprofit training and resource center for people providing care to elderly relatives or for organizations concerned about the needs of caregivers. The idea for the Center grew out of a seminar on the emotional and practical problems of caregiving that was pioneered by Dr. Carol Pierskalla who was then on the staff of the Center for the Study of Adult Development in Philadelphia. The Center's founders were determined that other caregivers should have the same relief, comfort and support that they had found in attending the seminar. Their first task, therefore, was to publish the seminar, *Help for Families of the Aging,* in the form of a workbook, three cassette tapes and a leaders' manual (see page __ for availability). Each chapter of the seminar workbook ends with an affirmation. These affirmations are reprinted and elaborated upon below in the hope that they will offer points of reflection for all people who are providing care to frail elderly relatives or who may assume that role in the future.

Jane Heald is Executive Director of the National Support Center for Families of the Aging.

The Affirmations

1. We accept each other without judgment and are willing to offer and receive mutual caring and support in total confidentiality. Acknowledging our stress and helplessness is a relief—as is sharing with others who understand how we feel because they also have struggled with grief, anger, confusion, anxiety, and compassion.

2. We are receptive to new skills and insights. The first thing we learn is to "Active Listen," without giving advice or making judgments. Oh, how hard it is to silence our own opinions and listen! What a surprise to discover the same skill improves our relationships with spouses and teenagers!

3. We are open to learning new ways of relating to the elderly. Perhaps we cannot solve their problems; we can still accept their feelings. Perhaps we cannot communicate verbally; we can still touch and hug.

4. We expect change as part of life; people can learn to understand and handle change. When an older relative becomes ill or disabled, most families go through a long adjustment process, beginning with denial. It is helpful if we can identify where we are in the process and learn, gratefully, that our feelings and behavior are normal.

5. We realize that we cannot control all the circumstances of our lives, nor of our loved ones' lives; we can work on our own reactions to them. Transitions sadden and frighten us. Talking with others who have faced readjustments gives us courage and practical ideas. If keeping things as they always have been is not an option, we can still respond constructively.

6. We believe that each person in our family—including ourselves—is entitled to a fair share of our time and resources. Justice means different things to different people, and life styles that would satisfy one might burden another, but of one thing we are sure: a sense of exploitation destroys love. The seminar teaches caregivers to claim space for themselves in the context of another's bottomless pit of need.

7. We help each other consider alternatives, acknowledging that we can be more loving to our aging relatives when we are comfortable with our level of involvement in their care. Taking responsibility for another's living arrangements is an awesome thing. We learn to research and evaluate options, to provide as much choice for the elderly as possible, and to negotiate a plan that considers the welfare of all. It is useful to think of oneself as a care *coordinator,* rather than a care *giver.*

8. We summon courage to look at the reasons for any compulsive behavior that is giving us trouble; we do not base our decisions on the approval of others. It is hard to contradict a parent we have always tried to please, to stand firm when a con-

Theresa and her mother Angela.

fused spouse makes irrational demands, or to choose another option when our cultural heritage tells us we must personally provide hands-on care. Understanding the sources of our expectations permits us to choose whether or not to fulfill them.

9. We admit that we cannot produce happiness for anyone else, including our aging loved ones; nor can we expect to fill all their needs. We are not God. It is not our fault loved ones are ill, nor our responsibility to live their lives for them. It's okay to let go of problems we can't do anything about.

10. We strive to clarify what is important to us and to consider any decisions on the basis of our true values, recognizing that any decision involves a cost. If life were simple . . . if we had only one loving relationship . . . if our own health and future were not important . . . decisions would be easy. Some caregivers have never before been asked, "What is important to you?" Setting limits with confidence demands an answer.

11. We search for meaning in our experiences and seek to appreciate the benefits of knowing our relatives in their old age. Love that survives loss gives us a hopeful model for our own old age. Knowing how to cultivate and maintain relationships is even more important than making practical plans for our own possible future dependency.

At the age of 97, physically helpless and almost deaf, Angela moved to a nursing home. The bonds of affection and appreciation between her and Theresa are as strong as ever. Angela has two daughters, four grandchildren, and eight great grandchildren. She says that she is very blessed. As Theresa concludes, "She's had a good life; she's had a lot of love."

TEACHING TOOLS OF THE NATIONAL SUPPORT CENTER FOR FAMILIES OF THE AGING

Publications
(All prices postpaid)

Help for Families of the Aging: a Small-Group Seminar. By Carol Spargo Pierskalla, Ph.D. and Jane Dewey Heald, M. S. Workbook and set of three cassette tapes, $17.95. Additional copies of the workbook, $8.95. For independent use by small groups of family caregivers. How to give comfort and support through non-judgmental Active Listening, identify solvable problems, help a friend generate alternatives, and determine which alternative is most appropriate for one's own situation.

Help for Families of The Aging: Leaders's Manual. $14.95.
Companion to the workbook. Steps for initiating a group for others. Sample news releases and registration forms. Effective leadership style. Pitfalls. Useful sentences. Hints, chapter by chapter. Adaptation, in six sessions, for families of nursing home residents.

Special offer, one workbook, one set of tapes, and one leaders' manual, $31.50

Families and Aging: Resources for Individuals and Groups. 14 pages. $4.75
Descriptive listing of over fifty advice books, personal accounts, manuals and curricula for group leaders, periodicals about caregiving, and catalogs of specialized products. Information about the emerging network of private geriatric care managers.

CHANGE: Bulletin of the National Support Center for Families of the Aging Quarterly. 8 pages. Subscriptions are $10/year for individuals, $15/year for libraries and other institutions.
Interviews, letters, health hints, financial planning, search for meaning, reviews, ideas for support groups. Published for caregivers, by caregivers. Useful also to professionals who want to understand and help families of the aging.

My Mother Hates the Nursing Home. Sixty-minute audio Sharing Cassette, $4.95.
Support group meeting taped in response to a letter and reproduced with permission. "How can we keep taking it when old people are complaining and disagreeable? Are there any ways to make a nursing home visit more pleasant for ourselves? How can we ensure that we won't become ogres when we sit in a wheelchair?"

Staff time permitting, the Support Center also presents training workshops to professionals interested in understanding and helping caregivers.

National Support Center for Families of the Aging
P.O. Box 245
Swarthmore, Pennsylvania 19081
Tel. (215) 544-5933

A Place To Help Yourself

Washington, D.C.'s New Senior Wellness Center

by M. Linden Griffith, M.P.H.

The "writing on the wall" of the Washington Seniors Wellness Center indicates a long future for a creative program that has only been in operation since May of 1985. On a large rectangle of paper, captioned "Expression Space," seniors are providing testimonials to a program that is making a significant difference in their lives.

"This place has made a new me in health and mind," wrote one enthusiastic participant. Other comments jotted down tell of the "helpfulness of nutrition and consumer education classes," the "wonderful feelings" experienced after participating in a fitness class, and of pride in being able "to get together (group power) on an attempt to get access to a swimming pool."

The comments in the "Expression Space" reflect other signs of growth in the participants—a new openness of self and a willingness to share attitudinal changes. "I expected *not* to like nutrition," one senior admitted, "but love the sessions now." Another woman, who had frequently said she dreaded getting old, announced to herself and her friends, "I am certain that I shall become an active young senior." But the comment that was really philosophically on target was "this is the place to help yourself." Self-responsibility is at the heart of the Center's program.

The wellness center concept for the District of Columbia was the brainchild of Office of Aging Executive Director E. Veronica Pace. The Office on Aging, which provided the funding, collaborated with the East of the River Health Association, a community-based, full-service health provider, in establishing the Wellness Center. In a recent report, Ms. Pace pointed with pride to the opening of the Center, describing it as "the District's first comprehensive, freestanding, preventive health organization whose primary mission is to teach and train older people to take charge and care for themselves."

Larry McSwain

Sylvia Holly takes center stage, while other older adults keep time in an aerobic exercise class at the Washington Senior Wellness Center.

The full-time staff consists of professionals trained in the disciplines of social work, nutrition, physical education, health planning and nursing. Helping the staff to round out the learning experience for seniors are other practicing health care professionals; program experts on health insurance, Food Stamps, and other services; and local artists. The Center is located in a small neighborhood shopping center, making it easily accessible to the large senior population in the immediate target area. The enrollment, however, is not restricted by locale.

There are four basic components to the Wellness Center program: Food and Nutrition/Consumer Education; Physical Fitness; Lifestyle Assessment (an initial screening tool); and Select Subject Matter, an umbrella category for health education and supportive topical areas. Among the services provided and problems addressed by the program are dental needs, hearing and vision screening, nutrition assessment, physical fitness, safe use of medications, smoking cessation, alcoholism, stress management, sexuality and aging, "life without mates," and assertiveness training.

The program is planned around a 12-week core curriculum, an educational and applied learning phase that helps seniors adopt a wellness philosophy and apply it to their lives. The demand, however, for continued involvement in the Center has led to an additional program of advanced classes and activities.

Initially, a new participant completes a battery of general questions which are designed to assess his or her life style. This health risk appraisal is used to assist the person to identify behaviors damaging to health and also to help staff determine priorities in designing health promotion activities. The assessment tool, coupled with the learning experiences planned, sets the stage for successful behavior change. A more in-depth inquiry is done on nutritional and exercise habits by the nutritionist and the physical fitness instructor.

M. Linden Griffith is Director of the Washington Seniors Wellness Center. Mrs. Griffith, received a B.S. degree in food and nutrition from Tennessee State University and a Master of Public Health from Johns Hopkins University.

Nutrition Facts Come Alive

Ask participants about the nutrition classes at the Center, and they are likely to tell you that some of the information was previously "known" but not really understood, that they are now applying it in their everyday lives. Learning about what it is in milk that makes it intolerable for many seniors and what to do about it, and sorting out the fiber story by identifying food sources for fiber are just a few of the practical bits of information absorbed.

Seniors learn to handle the paradox of knowing how to avoid cholesterol-laden diets while, at the same time, participating in the State Food Distribution Program that offers cholesterol-laden butter and cheese to eligible recipients. In the nutrition lab, seniors are shown how to decrease the amount of cholesterol in butter by blending an unsaturated oil with the butter for a palatable and less cholesterol dense "butter."

The Center's physical fitness program, developed with the assistance of a physiatrist from Howard University, requires a signed approval from a physician before the senior can participate. Awareness of self, based on the senior's predisposing condition, in conjunction with the advice of the physician and fitness instructor, set the limits for a safe regime, but one that is lively and fun. Heart rates are monitored, and individuals determine the period of time spent on each phase of the exercise routine, incorporating learned techniques if they suffer from a particular health problem.

The "Special Subject Matter" program component offers activities ranging from films on wellness and presentations by experts on Medicaid to creative work with local artists.

The Center does not provide transportation, but the absence of such a service in not a barrier. In addition to seniors who come on their own, others from the senior network agencies also participate. Approximately 12% of those who have attended the Center since it opened were aged 70 or older; several members are in their 80's. One gentleman, the oldest member, has just celebrated his 92nd birthday.

First Aid for Stress

Stress awareness and management hold a definable place in the program and play a subliminal role as well. Proper breathing is incorporated into exercises, and nutrition relates stress manifestations to dietary needs. But the participants learn about coping with stress in other ways by giving and getting spontaneous hugs—a ubiquitous trademark of the Center. The Center's weekly newsletter, called *The News Is Well,* also features a succinct message in each issue in a box, labelled "First Aid for Stress." One week it may say GETAWAYS in large letters, with "Spend Time Alone, See a Movie, Daydream" in smaller print. The message in the next issue may highlight ASSERTIVENESS—"State Your Needs and Wants," and "Say No Respectfully."

The newsletter's primary function, of course, is to present information on how to enhance wellness and to announce the times of Center classes and special activities, such as literary groups that gather to read aloud *The Color Purple.* But the newsletter also has a section called the "We Care Project" that mentions people in the hospital or ill at home who would love to have a phone call or a visit.

Like the "Expression Space" wall writings, the newsletter suggests that the Wellness Center is succeeding in creating a support network for seniors—a community in which they can join with others in changing stereotypes about capabilities in the later years. The Center is helping members to challenge their own and others' wrong notions about aging, notions that assume declining health and an inability to develop new friends, new interests and new enthusiasms.

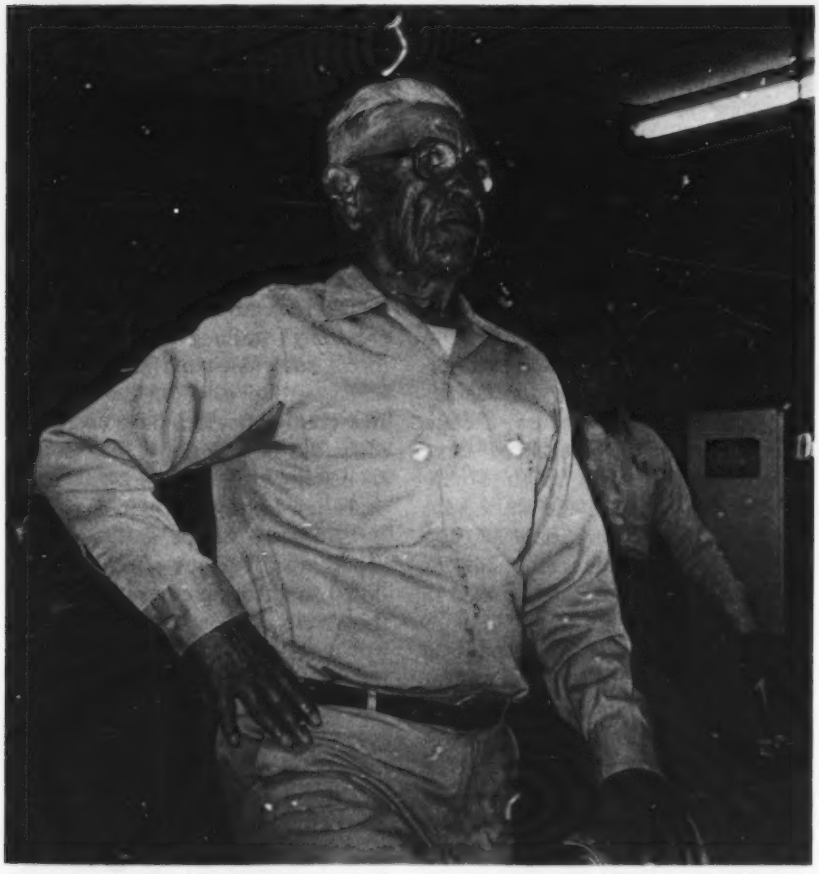
Stretching Health Promotion Resources

New Mexico's Living Better Longer Program

by Stephanie FallCreek, Ph.D.

On Wednesdays, 74-year-old Dorothy Wade, a former nurse, travels 120 miles down and back to Edgewood, New Mexico to lead a physical fitness group for seniors and offer nutrition education and crafts. On Tuesdays, she only has to go 30 miles upstate to an Indian Pueblo to conduct two fitness sessions in one day for Indian elders, and on Thursdays, it's a shorter trip to "work out" with Hispanic ladies at one of the Santa Fe senior centers.

Mrs. Wade says the seniors in Edgewood are "mostly ranching people, middle-income 'Anglos,' " Some are very overweight and get out of breath quickly, one member has suffered a stroke, but most are hale and hardy, including an 82-year-old woman who, Mrs. Wade says, "is the best in the bunch when it comes to keeping time." Commenting on the group's enthusiastic response to her crafts program, she says, "I teach crafts that require creativity—not painting by numbers."



Matias Medrano and other men who come to the Carcillio Senior Center join in the daily exercise routine.

The elderly Indian women in the two groups she runs upstate "are very modest," notes Mrs. Wade. "They wear skirts, not slacks, and don't like to do exercises where they kick their legs up from the floor, so I modify the routine." Mrs. Wade also teaches the Indian elderly cooking with wild plants, quilting and other "Anglo" crafts, and "lectures" on the customs of other Indian tribes throughout the U.S. "They really love that part of the program," reports Mrs. Wade, who is part Indian herself. Years ago when she discovered her Indian heritage, she says she learned all she could about her roots and also took courses in anthropology and ethnology at New York University.

According to Mrs. Wade, some of the Hispanic ladies in the exercise group in Santa Fe "feel worn out from working so hard all their lives. Sometimes, they will say, 'Oh Dorothy, I'm so tired, I can't do that.' " But Mrs. Wade says she makes them laugh and persevere with the exercise routine.

The distances Dorothy Wade has to travel each week and the diversity in the groups she serves illustrate some of the problems New Mexico has faced in setting up a statewide health promotion program for older residents. But the talents, background and enthusiasm she brings to the program also illustrate that the decision to use Senior Health Advocates was a good one in a state short of trained personnel and funds for health promotion programs.

Dr. Stephanie FallCreek is Director and Associate Professor, The Institute for Gerontological Research and Education, New Mexico State University, Las Cruces.

In 1983, the New Mexico State Agency on Aging started a Health Promotion with Elders Project which was reinforced by the Administration on Aging and the Public Health Service joint initiative on health promotion for older people. The following year, responsibility for the project was assumed by The Institute for Gerontological Research and Education (TIGRE) at New Mexico State University under a contract with the State Agency on Aging.

The Senior Health Advocates

A strategy of using older adults to initiate and staff health promotion activities was developed for a variety of reasons. New Mexico has a relatively small population of older adults, only about 185,000, although it is the sixth fastest growing state in terms of proportional increase of older adults in the population. Therefore, formula funding generates very limited Older American Act funds to support services other than those explicitly mandated by the Act.

Further, this older adult population is spread thinly across the state, with a majority living in sparsely populated rural areas, where senior centers and nutrition sites may operate only a few days per week, some without telephones or any full-time staff. Even if funds were available to pay for professional personnel in health promotion and disease prevention, such as health educators, nurses and exercise physiologists, in many cases, there are no professionals available to hire. Older adults themselves often can be the best inspirational models for their peers in undertaking health promoting activities and behavior changes. Also, in the spirit of senior employment programs, which have a goal of providing meaningful work as well as an income supplement, the job of "Health Advocate" certainly qualifies.

The Health Advocates, who are all over 55 and meet the income guidelines for Senior Employment positions, work approximately 20 hours a week in senior centers and nutrition sites across the state. Some advocates work in only one site, while others have a "traveling road show," serving as many as 5 to 10 sites weekly with fitness and educational sessions. Among the typical activities conducted or coordinated by the Health Advocates are health-related films; guest lectures; stress management workshops; and daily or weekly physical fitness programs, including "chairzercise," stretching and movement classes, aquatic exercise, gentle aerobics, walking groups and "race walking."

Each site is different, and programs must take into consideration the needs, interests and abilities of the target group as well as the available resources of the site sponsor. Some programs are conducted in Spanish, some rely on written materials, and others on demonstrations and audio visuals because of educational differences.

Training and TA

Since funds to support Health Advocate positions and training are limited, and may become even scarcer with the proposed budget cuts, it is important to support centers which do not have Health Advocates by providing training to volunteers and service providers and technical assistance to program planners and directors.

The State Agency on Aging offers regular training meetings which always include health promotion workshops. Last year, in collaboration with The Institute for Gerontological Research at New Mexico State, the agency sponsored three days of training, with health promotion as the focus of the workshops and general sessions. About 300 service providers and senior citizens from across the state participated in this meeting, which included sessions on health risk appraisal, physical fitness, special nutrition training for cooks and nutrition site managers, accident prevention, and stress management. This year, the theme of New Mexico's annual Conference on Aging, which attracts hundreds of elders and service providers, is "Living Better Longer," reflecting the priority given to strategies to promote physical and emotional wellness in older New Mexicans.

Dr. Jean Culbertson, the Health Promotion Training Coordinator from the Institute for Gerontological Research, has provided on-site training and technical assistance to more than 20 centers throughout the state, involving more than a thousand seniors. Recently, Dr. Culbertson has been concentrating her efforts in Dona Ana County and in other rural locations which have not had previous exposure to health promotion activities. She has worked with Ms. Liz Chavez, the contractor for 13 nutrition sites, and with staff and consumers at the sites to increase awareness of new ways to promote better nutrition at the meal site and at home.

Dr. Culbertson also collaborates with Ms. Jean Jewell, the public health nurse for Dona Ana County, to expand a wide range of health promotion activities at the 13 meal programs—everything from exercise, stress management and smoking cessation groups to seat belt and home safety.

Another person assisting with health promotion in Dona Ana County is Valerie Conner, the nutritionist for the Southwest Area Agency on Aging, who is on a 1-year contract as one of only two AAA nutritionists serving the entire state. In addition to providing training to about 100 cooks, cook assistants and other staff serving group meals in the 8-county area (many of whom have no formal education in nutrition), Ms. Conner is helping to introduce nutrition education for seniors.

"We get a lot of feedback from program staff to the effect that they don't do nutrition education because there's no one out there to provide it," notes Ms. Conner, who is working to identify personnel in the public and private sectors who can serve as resource people for the network on aging. "Western New Mexico University in Silver City and New Mexico State University in Albuquerque have home economics degree programs, Texas and New Mexico Power Co. has a home economist on staff, the

county Cooperative Extension Services have home economists, and so do local high schools," Ms. Conner points out. "Many of these people are willing to volunteer their time to provide nutrition education and other types of workshops to senior citizens." One program she would like to see tried in New Mexico is to train senior citizen volunteers to be "Senior Nutrition Advisors," an idea she says is already being successfully used in Minnesota and Arizona.

Special Projects

New Mexico's "Live Better Longer Task Force," which includes representatives of public and private health care organizations and of the network on aging, awards mini-grants for special projects. One about to get underway will make use of teenagers as exercise facilitators for Indian elders in six villages of the Pueblo of Laguna. Another project will do a videotape on nutrition designed for the Hispanic population, called "A Su Salud, Dona Lupe."

The Task Force is also sponsoring a statewide "Brown Bag" campaign on using medications wisely, in cooperation with local pharmacists. Nearly two-thirds of the pharmacists in New Mexico have agreed to set aside noon to 2 p.m. each Wednesday in June for consultations with senior citizens about their medications. Approximately 50,000 "Brown Bags" which the elderly can use to transport their medications are being distributed through senior centers, hospitals, public health clinics, pharmacies, and retirement communities to publicize the free consultations.

There are many other possible public-private sector collaborations that could create an environment in which older residents from all income and ethnic groups could make healthier life-style choices—choices that will mean "Living Better Longer" in New Mexico.

Confused About Caffeine?

Although there has been much conflicting research data on the effect of caffeine on health, many experts agree that Americans would be better off if they reduced their consumption of caffeine—especially those persons who are at risk of heart disease or cancer.

Coffee drinking today accounts for 75 percent of all caffeine intake, and tea about 15 percent. Toronto psychologist Richard Gilbert, in a review of coffee consumption trends since 1962, has stated that "coffee changed during (the last) two decades from being a beverage drunk by most age groups at many times of the day, to one drunk mostly by middle-aged and elderly adults at breakfast or probably shortly thereafter." More than one-half of all adults in the U.S. continue to drink an average of nearly 3½ cups of coffee each day, although overall per capita consumption of coffee by Americans dropped to 1.83 cups per day in 1985. But consumption of soft drinks, most of which contain caffeine, has more than doubled since 1962. Generous amounts of caffeine also are found in such diverse products as chocolate, various medications (for colds, headaches, allergies, and weight control), and even in certain baked goods, frozen dairy products, and sweets.

While some experts suggest that caffeine helps us to think more clearly, perform more efficiently, and improve physical endurance, we know that it also affects the circulatory system by widening coronary arteries and pulmonary vessels, increasing blood flow to the heart. Abnormal heart rhythms, increased kidney and bladder action, trembling, chronic muscle tension, and insomnia can occur in some persons with certain levels of caffeine intake.

Isolating the effects of caffeine from other possible risk factors is a major difficulty in caffeine research. In late 1985, Johns Hopkins University reported the results of a 35-year study of more than 1,000 graduating physicians. One major finding was that those persons drinking five or more cups of coffee each day had almost three times greater risk of having heart problems than non-coffee drinkers. This study also indicated that heavy consumption of coffee alone created a greater likelihood of heart disease—even when controlled for factors such as smoking, age, and cholesterol count.

However, another highly respected longitudinal study, the Framingham, Massachusetts Heart Study, after following the health records of participants for more than 30 years, found no connection between caffeine and heart disease. Similar conflicting research results have been found with a possible link between caffeine intake and the incidence of fibrocystic disease in women, a painful, though noncancerous condition, of the breasts.

The role of caffeine on health may remain unclear and controversial for some time. The American Medical Association has indicated that people who consume moderate amounts of tea and coffee "probably need have no concern for their health related to their caffeine consumption, provided

other life-style habits (diet, alcohol consumption) are moderate as well."

There are, however, some practical alternatives for consumers who use products containing caffeine. If you drink coffee or tea, consider switching to decaffeinated brands. Even though decaffeination processes do not remove all caffeine, the levels of this substance are greatly reduced. Persons who suffer from ulcers and other stomach problems should not drink any kind of coffee without consulting their physicians. Some doctors advise that persons who already have heart problems should avoid caffeine completely. To reduce withdrawal symptoms, which many heavy coffee drinkers may experience, caffeine intake should be reduced gradually; try reducing coffee intake 1–2 cups per day. Many soft drink brands also have decaffeinated versions.

Most importantly, consult your physician about the use of caffeinated products if you are in a high risk group. Also, make it your responsibility to read carefully the labels of the products you buy to determine the presence of caffeine. You may be helping yourself to better health.

Caffeine Content

DRINKS

Average Mg. of Caffeine

Coffee (5 oz.)	
Brewed, drip	115
Brewed, percolator	80
Instant	65
Decaffeinated, instant	2
Decaffeinated, brewed	3
Tea (5 oz.)	
Brewed, imported brands	60
Brewed, major U.S. brands	40
Instant	30
Iced (12 oz.)	70
Cocoa (5 oz.)	4
Milk Chocolate (1 oz.)	6
Bittersweet Chocolate (1 oz)	20
Chocolate Cake (average slice)	20–30
Soft Drinks (12 oz.)	
TAB	46.8
Coca-Cola	45.6
Diet Coke	45.6
Dr. Pepper	39.6
Pepsi Cola	38.4
Diet Pepsi	36.0
Mountain Dew	54.0
Canada Dry Diet Cola	1.2

All such averages are widely variable. For instance, loose tea has more caffeine than tea in bags. Also the dosage of caffeine per cup of tea increases an average 20 mg. for every extra minute you brew. Brewed coffee will have similar variations in total caffeine content.

NONPRESCRIPTION DRUGS

Mg. Caffeine, One Tablet

Weight control aids	100–200
Alertness tablets	100–200
Analgesic/pain relief	30–65
Diuretics	100–200
Cold/Allergy remedies	16–30

Note: While caffeine widens coronary arteries, it conversely *constricts* blood vessels in the head. Migraine headaches can be caused by dilated blood vessels, hence caffeine's use in headache medicines.

This chart is reprinted from the January 1988 issue of *50 PLUS* magazine.

Never Too Old To Quit

Organizations throughout the country are responding to Surgeon General C. Everett Koop's call for a smoke-free society by the year 2,000 through objections to cigarette advertising, promotion of nonsmoking in the workplace, reports on the devastating health effects of the addiction, and new efforts to help smokers stop.

According to the National Institute on Aging, "over 30 million Americans have been able to quit smoking," and there are many groups and agencies that are helping to continue the decline. Among them this year will be the Administration on Aging, which will include smoking cessation as one of the goals of a health promotion campaign that the agency is conducting jointly with the Public Health Service.

One organization well known for its long campaign against smoking is the Adventist Health Network, which has changed the name this year of its popular program, the "5-Day Plan To Stop Smoking," to the "Breath-Free Plan To Stop Smoking." The new program runs for eight days and is conducted jointly by graduates of previous programs who have stopped smoking and professionals, such as physicians, health educators, psychologists, nurses, and chaplains.

"In the new plan, reports are showing close to a 100% success rate at the end of the eight days," notes Stoy Proctor, Executive Director of the Adventist Health Network. "Of course, we are very concerned

with what happens after the eight days and are stepping up our follow-up efforts."

Proctor also notes that the Network, which used to run almost all its smoking cessation programs out of hospitals and churches, is now approaching companies with plans to hold the sessions in the workplace.

Further information about local "Breathe Free" programs can be obtained by calling a nearby Seventh Day Adventist Church or calling the Adventist Health Network's toll-free number, 1-800-253-7077.

For those who do not like group sessions and would like to quit smoking on their own, the American Lung Association (ALA) is offering two self-help manuals or a new video cassette package for use at home.

According to Karen Monaco, a program manager at the ALA, "An estimated 95 percent of smokers who quit do so on their own rather than in a clinic setting."

The two manuals available from the ALA are *Freedom from Smoking in 20 Days* and a maintenance manual, called *A Lifetime of Freedom from Smoking*. Most smokers "practice quitting" before they finally succeed, says Ms. Monaco, who also notes that the manuals have proved to be a "continuing resource" for people fighting the addiction. The set of manuals costs $7.00 and can be ordered from local chapters of the American Lung Association.

The ALA's new video cassette package, designed to serve the same purpose as the manuals, is called *In Control: A Home Video Freedom from Smoking Program*. The package includes a color video cassette in 13 9-minute segments, an audio cassette, and a 136-page book to reinforce the information presented.

Dr. Nina Schneider, a UCLA psychologist narrates, and Steve Garvey, San Diego Padres first baseman, assists. Topics covered include awareness of what triggers the impulse to smoke, coping tools for nonsmoking, rehearsing for problem situations, benefits of nonsmoking, tension reducers, weight control, exercise, and use of nicotine gum.

The video casette package costs $59.95 and can also be ordered through local chapters of the American Lung Association.

The numerous articles written about smoking cessation often emphasize the benefits to the young and middle-aged. However, the experts concur that the elderly can definitely improve their health and lower risk of cancer and heart disease by giving up cigarettes, regardless of how many years or how many cigarettes they have smoked.

One recent article in the *Journal of the American Medical Association* (May 24–31, 1985) reports on a study which found that elderly persons who stop smoking can increase their cerebral blood flow (CBF) levels. The study compared CBF levels in 268 normal volunteers whose average age was 60. The researchers found that the smokers had the lowest CBF levels and that those who had never smoked had the highest. But, those who had stopped smoking had significantly higher CBF levels than the smokers.

According to the National Institute on Aging, there are many ways to stop smoking. No single method works for everyone, so each person must try to find what works best. Most people stop on their own, but others need help from doctors, clinics, or organized groups. Some studies have found that older people who take part in programs to stop smoking have higher success rates than younger participants. Organizations, doctors and clinics offering stop-smoking programs are listed in the yellow pages under "Smokers' Treatment and Information Centers."

For employers interested in protecting nonsmokers and in helping smokers to quit, the Public Health Service has published a new report called *A Decision Maker's Guide To Reducing Smoking at the Worksite*. It describes why and how an increasing number of employers are deciding to eliminate or restrict smoking at the worksite and provides examples of businesses with smoking policies and smoking cessation programs. The report was cosponsored by the American Cancer Society, The American Heart Association and the American Lung Association. Copies may be obtained from: The Office of Disease Prevention and Health Promotion, Public Health Service, Department of Health and Human Services, 330 C St., S.W., Washington, D.C. 20201, (202) 245-7611.

The Federal government also offers free materials on smoking cessation, including: *Cleaning The Air: A Guide to Quitting Smoking; No More Butts: A Guide to Quitting Smoking; What You Don't Know Will Hurt You: A Guide to Smoking and Your Health*. These pamphlets are available free from: Office on Smoking and Health, Department of Health and Human Services, 5600 Fishers Lane, Parklawn Building, Room 110, Rockville, Md. 20857 (301) 443-1690.

HEALTHY OLDER PEOPLE

Safe use of medications is one of the topics covered in skill sheets issued by the PHS Healthy Older People program.

Public Health Service "Healthy Older People" National Campaign.

"Healthy Older People" is a national program designed to improve the health habits of millions of older Americans. The program, sponsored by the U.S. Public Health Service's Office of Disease Prevention and Health Promotion (ODPHP), helps older people avoid potential health problems by educating them about the benefits of adopting certain healthy behaviors. Specifically, the program encourages older people to improve their health by eating right, exercising regularly, using medicines safely, giving up smoking, and preventing injuries.

ODPHP launched Healthy Older People in an effort to meet the health needs of the growing number of older Americans. Studies have shown that older people are interested in improving and maintaining their health and are actively seeking information to do so. However, like other age groups, older people may find it difficult to sort through conflicting information on health habits, and they often lack information on which illnesses, such as cancer or heart disease, are linked to certain behaviors. In addition to educating older people about how adopting these five habits can help improve their health, the Healthy Older People program also seeks to stimulate the growth of health promotion programs for older adults at the local and state levels.

In conjunction with the health promotion initiative sponsored by the Public Health Service and Administration on Aging, Healthy Older People relies on a network of individuals appointed by the governors to implement the Healthy Older People program within their state or territory. These state contacts have the ultimate responsibility for determining how they will use Healthy Older People materials to support their own health promotion activities for older people.

Most of the state contacts have established an area network of state and local government officials, health professional organizations, trade associations, voluntary groups, and businesses to help get program materials in the hands of older Americans. The state contacts' efforts complement the efforts of the Healthy Older People national staff, which secures the participation and support of national organizations.

Some of the organizations participating in Healthy Older People include the American Red Cross, the American Hospital Association, and the American Association of Retired Persons (AARP). Their support includes such activities as underwriting the printing or distribution of program materials, encouraging their members to participate in the program, developing health promotion programs for their members, publishing articles featuring health promotion information for older people, and sharing information on their own programs. Of special note, AARP paid for the production of television public service announcements, and the American Hospital Association sponsored an educational teleconference for professionals.

The Healthy Older People materials include radio and television public service announcements, news and feature programming for television and radio, skill sheets, posters, and press kits. All of these materials offer specific steps that older people can take to eat better, exercise regularly, quit smoking, prevent injuries, and use medicines safely. Companies and organizations that purchase the posters or skill sheets can personalize them with their name or logo.

The national staff also runs a toll-free hotline that interested people or organizations can call for information on Healthy Older People or on creating health promotion activities and programs for older adults. The hotline operates every weekday from 9 a.m. to 5 p.m. (EST). The toll-free

number is 800-626-5433 (202-342-7084 in Alaska and Washington, D.C.).

The Healthy Older People program staff can help identify ways for interested organizations to participate in the program, regardless of whether the group is large or small and regardless of whether it works directly or indirectly with older people. Groups interested in participating or seeking more information should call the Healthy Older People hotline.

Sexual Health For Older Adults

Sexual health education for older adults is a topic of growing interest to senior citizen groups and to professionals and other staff assisting the elderly. Recent studies substantiate that an active sexual life can be a choice for many, if not most, seniors.

"Sexual health" refers to sexuality as an attitude of mind as well as a bodily function; a comfortable accommodation with one's sexuality in the later years of life is an important part of general physical and mental health.

In response to the growing demand for education in this area, the University of Iowa Gerontology Project has designed a program for training individuals to conduct sexual health education workshops. The training program covers such topics as sexual health and its relationship to general health; the changing physiology of aging and its effect on sexual interest and function; the changing psychology of aging as it affects sexual interest and function; chronic illness and impairment and how these might compromise sexual health; the effects of drugs and other therapies; and tips on how to maintain and strengthen sexual interests and vitality in the later years. In response to requests from hospitals and nursing homes for in-service programs for their staff, a special unit has been developed to help long-term care institutions respect and respond to the sexual needs of their residents.

There is a growing literature on the subject of sexuality in later life. *Love and Sex After Sixty* by Robert Butler and Myrna Lewis (Harper & Row, New York, 1976) remains one of the classics. Alex Comfort's *The Joy of Sex* (Simon & Schuster, New York, 1972) is another frequently read book on this subject. The University of Iowa Gerontology Project is publishing a new book on *Sexual Health in the Later Years,* written for older adults and for those wishing to conduct workshops on sexual health. Written by Dr. Thomas Walz and Ms. Nancee Blum, the book is due to the released by the Fall of 1986.

The Gerontology Project has also developed a number of sexual health audiovisual teaching aides, including the Adult Sexual Knowledge and Attitude Test (ASKAT). The latter is a test developed by University of Iowa gerontologists to measure the accuracy of one's knowledge about the ways in which advancing age affects sexual interest and function. The ASKAT is useful in conducting an information needs assessment in senior groups prior to offering sexual health education programs.

For more information about the University of Iowa Gerontology Project sexual health education program, please contact Dr. Thomas Walz, School of Social Work, University of Iowa, Iowa City, Iowa 52242.

(This article was written by Thomas H. Walz, Ph.D. and Nancee S. Blum, B.A.)

Immunization Isn't Just Kid Stuff

Ask most Americans what they think of when they hear the word "immunization" and they will tell you about "baby shots." Yet millions of adult Americans, particularly the elderly, are in need of one or more immunizations. There are seven serious, sometimes fatal, diseases affecting adults which can be prevented by currently available vaccines and/or toxoids. These diseases are influenza (commonly referred to as "flu"), pneumococcal disease, hepatitis B, tetanus, diphtheria, measles, and rubella.

Each of these disease strikes hardest at specific groups of adults. Influenza and pneumococcal disease pose the greatest danger to those 65 and over and to individuals with chronic diseases such as heart or lung disease and diabetes. Hepatitis B threatens health care workers, kidney patients, homosexually active males and others. Tetanus no longer commonly occurs in the United States, but it still claims the lives of nearly half its victims over 60 years of age. The number of diphtheria cases has also dropped, but the disease is still most dangerous to two very vulnerable groups—infants and the elderly.

Measles epidemics are still occurring on college campuses and are associated with significant illness, even death. Rubella infection still occurs in susceptible pregnant women and can result in a miscarriage, a stillbirth, or birth of a congenitally deformed infant.

Protection against influenza, tetanus, and diphtheria requires periodic booster immunizations throughout life. Annual immunizations against influenza are needed by the elderly and the chronically ill because the flu virus reappears, sometimes in new forms, every year. Tetanus-diphtheria boosters are needed by everyone at least every 10 years.

Pneumococcal vaccine need only be given once. Immunity from hepatitis B vaccine is developed through a 3-dose series of shots over a period of six months. The duration of protection from pneumococcal and hepatitis B vaccines is not yet known but no booster doses are recommended at this time. One shot against measles and rubella provides long-lasting, probably lifetime, protection to all age groups.

Immunizations can be obtained from State or local health department clinics, private physicians and some hospitals. Fees charged for these vaccines depend on which vaccine is received and the office or clinic where it is administered. The administration of these vaccines may be covered by health insurance; pneumococcal vaccine is a reimbursable expense under Medicare. All are considered safe and effective and are recommended by medical authorities as part of a general maintenance program for adults. Not every adult is in need of each of these vaccines and toxoids, however, so it is wise to call your doctor or clinic first to discuss which immunizations you need and then schedule a visit to receive them. Every adult, however, should keep a personal, permanent record of what vaccinations are received and when.

The same widespread interest and concern which has prompted parents to ensure that their children are fully immunized now needs to be directed at parents, and grandparents, to ensure that they are also protected. Immunization isn't just kid stuff—it's the adult thing to do!

Five Dietary Rules For Better Health

What should you eat to stay healthy? Hardly a day goes by without someone telling us what we should and should not eat. Advice is everywhere—on radio and TV; in magazines, newspaper, billboards; and from friends. Some of the confusion exists because we do not know enough about nutrition to identify an "ideal diet" for everyone. Each person is different, and their food needs differ according to age, physical activity, sex, and other condition, e.g., pregnancy and illness.

Research continues to give us more information about the amounts of essential nutrients people need and diet's suspected role in certain chronic diseases, such as heart disease, high blood pressure, stroke, diabetes, osteoporosis, and some forms of cancer. Recently, the contribution of diet to the overall risk of cancer has received much public attention.

Although research on the relationship between diet and chronic illness continues, there are some general guidelines which one can follow in selecting and preparing foods to ensure good nutrition. The nutritional guidelines, published by the U.S. Departments of Agriculture and Health and Human Services, are suggested for most Americans who are already healthy. They do not apply to persons who need special diets because of diseases or conditions that interfere with normal nutritional requirements. These persons may need special consultation with registered dietitians or their own physicians.

Two guidelines form the framework for a good diet—*"eat a variety of foods"* that provide enough of essential nutrients and energy (calories) to *"maintain desirable weight."* An adequate daily diet contains a variety of foods, including selection of fruits, vegetables, whole-grain and enriched breads, milk products, and lean meats, poultry, or fish. Generally, a person's desirable weight as an adult should not be much more than what it was at age 25, if it was a good weight then.

Five other guidelines describe special characteristics of good diets for Americans:

- *Avoid too much fat, saturated fat, and cholesterol*—this is especially important for persons with cardiovascular risk factors, such as smokers or those with histories of premature heart disease, high blood pressure, and diabetes.
- *Eat foods with adequate starch and fiber,* including whole-grain breads and cereals, fruits, and vegetables.
- *Avoid too much sugar*—sugars provide calories but few other nutri-

ents; read labels carefully to determine the proportion of sugar in the products you buy.

- *Avoid too much sodium,* which is a major hazard for persons with high blood pressure. Again, read food labels carefully, since many foods contain "hidden" sodium that occurs naturally in the food product or as part of a preservative or flavoring agent.
- *If you drink alcohol, do so in moderation*—alcoholic beverages are high in calories and low in nutrients.

It should also be noted that although water is not a nutrient, water is an important part of a good diet.

For additional information on how to use the dietary guidelines, write to Human Nutrition Information Service, U.S. Department of Agriculture, Room 325A, Federal Building, Hyattsville, Md. 20782. For additional help with diet and health questions, write to Consumer Inquiries, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD. 20857.

New Cancer Society Prevention Program

Mention the word "cancer" and most people experience a feeling of great fear. Many persons have an equally deep sense of hopelessness about the prevention of this disease.

"Taking Control" is a new cancer prevention public education program announced by the American Cancer Society (ACS) which integrates all aspects of cancer prevention: diet; exercise; and, general health habits. Workplace seminars, churches, and supermarkets will be some of the major settings in which this program and materials will be offered by the Society's 3,242 local units.

The public education program offers 10 steps in cancer prevention. Five involve the following habits *to adopt:*

- Increase consumption of fresh vegetables;
- Add more dietary fiber, e.g., by eating whole-grain breads and cereals—wheat, bran—and fruits and vegetables;
- Increase your intake of vitamin A through such sources as carrots, apricots, broccoli, and sweet potatoes;
- Add more foods rich in vitamin C, including all citrus fruits, cantaloupe, cabbage, spinach, cauliflower, and tomatoes; and,
- Practice weight control.

Five other steps recommend habits *to stop or curtail:*

- Stop cigarette smoking;
- Reduce amounts of dietary fat;
- Reduce intake of salt-cured, smoked, and nitrite-cured food;
- Go easy on alcohol; and,
- Avoid overexposure to the sun.

Additional information on this prevention program is available from the American Cancer Society at 4 West 35th Street, New York, New York 10001.

Colorectal Cancer: Early Detection Vital

Very few people are interested in talking about cancer of the colon or rectum. Everyone over 40 years of age should, however, because this disease is a killer that *can* be detected and cured in its early stages. By the end of this year, approximately 60,000 persons in the U.S. will die of colorectal cancer and another 138,000 will have been diagnosed with the disease. After lung cancer, cancer of the colon is the most prevalent form of cancer, representing 15 percent of all cancers in American men and women.

There is, as yet, no identified cause of this disease, but current research suggests that dietary patterns play a significant role. The American Cancer Society (ACS) indicates that high-fat, high-protein diets are suspected villains, while fiber-rich diets are considered by some scientists as an important way to reduce the risk of colon and rectum cancer. The average person has 1 chance in 20 of developing colorectal cancer. After the age of 40, the risk doubles every decade, e.g., at age 50 the risk is 1 chance in 10 and at age 60, 1 chance in 5. The risk is even higher for someone whose parents or siblings have developed the disease.

Early detection is still the best means to improve the survival and cure rates for this problem. Persons with colorectal cancer can be saved in more than 75 percent of the cases, when it is found early and treated promptly and properly. The key word here is *early*. Approximately 10 percent of the population has benign polyps of the colon, lesions that eventually may develop into colon cancer. The problem, of course, is that persons with benign polyps may not know it in the early stages of the disease.

Since cancer of the colon and rectum is a relatively slow-growing disease, there is considerable hope in early detection. Its detection, however, is up to both one's physician and to each person over age 40. Getting a regular check-up is an important step. The most widely used screening test is a "Procto" exam, a procedure by which your doctor can use a slim lighted tube to see directly into the lower bowel and rectum. This exam ensures early detection of cancer in this part of the intestinal tract, when it may be more easily cured by prompt treatment and often without major surgery. But each of us can also participate in the early detection of this disease through an easy-to-use home detection kit called the CR Test (or Guaiac), designed to check for hidden blood in the stool. This test is easy, painless, and private. The CR Test kit is available from your doctor or free to persons over 21 from the American Cancer Society. Call your local chapter of the ACS for further information.

Seminars for Employees on Caregiving

Health of caregivers, a growing concern

by Mimi Aarens

The 50 employees of a management consulting firm who had signed up for a workshop on caring for elderly relatives listened sympathetically as a co-worker expressed his doubts over a decision to place his father-in-law in a nursing home.

My father-in-law was enjoying his new condominium and his new neighbors. Despite what he'd been through, he'd made a pretty good adjustment after his wife was institutionalized because of Alzheimer's disease. He's a gregarious man, and his days could have been described as productive and upbeat. But every once in a while he would faint; sometimes he hurt himself and became panicky. His doctor said 'nothing to worry about, low blood pressure.' But the fainting spells became more frequent and we were worrying more and more about leaving him alone. The number of daily spells began to mount. My wife was calling him every few hours and then spending whole days JUST WATCHING HIM. I was using up my leave time in trips to the doctors, emergency rooms and hospitals. We knew that we would have to take a new look at his living situation.

As hard as it was, we had to acknowledge that Dad needed round-the-clock supervision; it was just too dangerous for him to be living alone. The next step was to make the arrangements for him to go to the same nursing home as his wife. He hates being there, with the 'sick' and 'elderly' crowd; he's become depressed, and my wife and I are struggling with our own feelings of helplessness, wondering if we did the right thing.

There were many others in the room that day who felt guilty and frustrated over a similar situation, and they were grateful that their employer, a management consulting firm, was attempting to help them with a new kind of employee service.

The firm is one of five Massachusetts corporations that have contracted with Somerville-Cambridge Elder Services, Inc. for the delivery of educational workshops on issues relating to aging and caregiving. Somerville-Cambridge Elder Services is a private nonprofit organization that provides homecare, transportation, nutrition, employment, and other services to 6,000 older citizens in Somerville and Cambridge, Massachusetts. Among the firms participating in the agency's workshop series, which is called "Elderlink," are Charles Stark Draper Laboratory, Somerville Lumber, the City of Somerville, Bolt, Beranek and Newman, and Arthur D. Little & Co.

These corporations have acknowledged an increasing problem in the workplace—the pressures on millions of American workers who are responsible for the day-to-day care of an aging parent or relative. This added responsibility often spells STRESS, which translates into absenteeism, lower productivity and, in some cases, unnecessary employee turnover. Some of the most stable and experienced employees—those ranging in age from their 40's through their early 60's—are taking care of one or more older relatives, helping with grocery shopping, trips to medical facilities, and hands-on health care. These men and women are juggling caregiving responsibilities with their careers and the demands of their spouses and children, a predicament that is likely to become more common in the future. As more and more Americans live to a ripe old age, the pressure on younger family members will undoubtedly intensify.

The Elderlink seminar series is an attempt to link the non-profit support network for the elderly to the private sector, the home to the workplace, and the concerns of management to the needs of employees. The professional facilitators of the workshops help employees to cope with problems involving frail, elderly relatives by discussing the issues of aging and identifying local support services. The workshops are targeted to employees who are, or might become, caregivers, or who are concerned about their parents' and their own aging.

The goal of the program is to assist employees in planning for and resolving issues concerned with aging and care of elders *before* they become huge problems. Topics covered are "Community Resources and How to Access Them," "You and Your Aging Relative." "Myths and Realities of Aging," "The Aging Process—Physical and Social Aspects," and "Use of Leisure Time for Retired People." The program curriculum includes mini-lectures, worksheets, questionnaires, handouts, and two films, "My Mother, My Father," and

Mimi Aarens is Director of Community Affairs for Somerville-Cambridge Elder Services, Inc. in Somerville, Massachusetts.

"Over the hill"—one of the myths of aging being explored with seminar participants by Bernice Borison, Elderlink's former project director.

"Ruth Stout's Garden." Each attendee receives a folder of detailed information on medical, social and educational resources as part of the "Community Resources" seminar. The trainers are professional staff from Elder Services.

Over the years, the staff at Somerville-Cambridge Elder Services has become increasingly aware of work-related stress in the lives of family caregivers. This concern led to the development of a proposal for the Elderlink program, which originally envisioned delivery in the workplace of both educational and case management services to caregivers and their families. The project received a grant from the Administration on Aging in the fall of 1984 and was underway several months later.

Bernice Borison, the former project director, made personal presentations to 12 corporations. Her discussions with managers revealed that the only corporate programs touching on the subject of aging involved pre-retirement counseling which is clearly not appropriate for younger employees. It also became apparent that none of the existing employee counseling programs had established links with the labyrinth of support services for the elderly, which are channeled through Area Agencies on Aging and home health care agencies.

While the personnel departments were very interested in the seminars and workshops, they were resistant to the idea of delivering case management services to caregivers in the workplace. This kind of information and referral was not considered to be an affordable employee benefit. As a result, Somerville-Cambridge Elder Services has temporarily shelved that side of the project, but there are plans to pursue it in coming years.

The agency will also be using participant evaluations and comments in seminars to refine the workshop series. Some of the problems repeatedly raised were: financial planning for aging parents; the desire for more information on retirement planning; the need for information on nursing homes, with respect to quality care and financial arrangements; and advice on determining when it is time to consider nursing home placement for an elderly relative.

Many workshop participants also expressed relief that their community and their employer were showing concern about the welfare of caregivers. One engineer in his 50's remarked: "Finally, someone is acknowledging that WE have a problem. Not just my aging parents or in-laws, but my wife and I! WE also need the support and information; WE need to set priorities for our children and ourselves. No one has been paying attention to OUR needs as caregivers! For the first time, I feel that I'm not alone. Thank you!"

But Elderlink's previous director, Ms. Borison, knew that her program had a long way to go in raising the level of awareness in the workplace of caregiver problems. "We see that a slow educational process must take place with each client corporation," she commented after the program's first year of operation. She said Elder Services could help by continuing to offer the workshops and by sharing brochures on community resources with employers. The employers could do their part by using internal communication systems to highlight medical findings, estate planning, and other information relating to aging and care of elders. "Ultimately, the agency hopes to include a case management referral service to support individual employee/caregiver needs," noted Ms. Borison.

John O'Neil, Executive Director of Somerville-Cambridge Elder Services, also sees the workshop series as the first chapter of the program. "We are planning to market Elderlink as a self-supporting, fee-for-service program, incorporating the original case management component as an adjunct."

For further information, contact:

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Wellness Is More Than Exercise

Health promotion at a senior meals program

By Jo Meserve Mach and Joyce Gorsuch-Burns

The "Self-Esteem Game" makes sharing thoughts and feelings easier.

Every day Margaret and Harold sit side by side in silence while eating their lunch at the senior meals program. Afterward, they climb into the community van to be driven back to their separate and silent homes. Each is unaware of their own specialness, and so they do not share themselves with each other.

Margaret and Harold's situation is not unusual. Many of the older adults who meet each day at meal sites, senior centers and retirement communities really don't know one another. These older individuals have so much to offer, and yet they are often unaware of their potential for growth.

"Living It Up" is a community wellness program which was developed for the individuals described above—seniors who tend to remain within their private worlds. It is a program based on the belief that within a group setting, older individuals can motivate one another to achieve personal wellness and experience the joy of being alive.

Sponsored by the Topeka-Shawnee County Health Department, the wellness program is currently carried out at senior nutrition sites in Topeka, Kansas. The authors developed the program in 1984 and served as co-leaders of several groups until July 1985.

"Living It Up" is a 6-week program which meets for 90 minutes two times a week. When the authors conducted the program, a typical session included:

- Reading an excerpt from a book or publication to promote a positive outlook;
- Exercising to music popular with the participants (all exercises can be done while sitting);
- A presentation on a topic related to wellness; and
- A group activity requiring social interaction.

The group activity reinforced the aspect of wellness being discussed. For example, during the session on self-awareness, the "Self-Esteem" game was played in which participants were asked to write positive comments on paper attached to other participants' backs. Long lines formed as messages were written. Most agreed these thoughts were easier to write than they would have been to say. In general, the authors found that the participants felt freer to share thoughts and feelings with others within the structure of a game or activity.

The environment created during each session is as important as the program content. The atmosphere needs to be informal, supportive, accepting, enthusiastic, mildly competitive, non-threatening, and above all, fun.

Program topics included: self-awareness, stress management and relaxation, information on medications, assertiveness training, safety information, plant therapy, dancing, nutrition, reminiscing, interesting activities to pursue, and exercise. The topics for each program were chosen by the participants through a questionnaire completed prior to the first group session.

Some of the presentations were adapted to meet the specific needs of individuals in the group, such as

Jo Meserve Mach, a registered occupational therapist, and Joyce Gorsuch-Burns, a licensed social worker, developed and were co-leaders from July 1984 to July 1985 of the "Living It Up" program, which is sponsored by the Topeka-Shawnee County Health Department.

those who were hard-of-hearing. For example, the assertiveness training session included discussion of the ways that the hearing impaired could improve communication.

At the conclusion of each 6-week program, a graduation party was held. The "graduates" received certificates of achievement for attending the program, along with "Living It Up" T-shirts, which helped to promote group identity.

Several positive results were apparent by the end of each 6-week program. Many new friendships were formed among group members who had barely spoken to one another before the program began. An increased awareness of the need for exercise and the importance of remaining active was demonstrated by their willingness to meet regularly as a group under their own leadership. Participants also displayed more assertive behaviors, and significant changes were noted in their ability to interact and share with others.

Much has been written about the importance of wellness, often with the emphasis on exercise. However, the group leaders discovered through their involvement with "Living It Up" that providing information or exercise does not guarantee wellness. The success of this wellness program depended upon promoting self-worth in the participants. It is only by realizing self-worth that individuals can make a real commitment to their own wellness.

For further information:

Jo Mach or Joyce Burns
Topeka-Shawnee County Health Department
1615 W. 8th Street
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(913) 233-8961 Ext. 222

3,000 Seniors Join Statewide Walking Clubs In Massachusetts

The great pleasures of walking, often overlooked in this vehicle-dependent society, are being rediscovered by Massachusetts seniors, who are taking to the sidewalks and back roads again. The regular "constitutional" is back in vogue.

The senior citizens are members of a program called "Keep Moving," which includes a statewide network of walking clubs and the annual Governor's Cup competition. Designed by the Executive Office of Elder Affairs to promote exercise, fitness, and socialization, the Keep Moving program was launched a year ago by Governor Michael S. Dukakis and Elder Affairs Secretary Richard H. Rowland.

"Over 3,000 elders have enrolled in community-based walking clubs throughout the Commonwealth and the membership roster increases weekly. We are very excited and encouraged by the success of this program," said Elder Affairs Secretary Rowland. "Membership in Keep Moving has exceeded our expecta-

Comraderie and fun at the Governor's Cup 3-mile walk.

tions. Walking with friends in their communities, Keep Moving club members are enjoying the exercise and the camaraderie."

Working through a network of 331 Councils on Aging, senior centers, park and recreation departments, community centers and Y's, the Executive Office of Elder Affairs and the USDA Human Nutrition Research Center on Aging at Tufts University train volunteers to organize and run the community-based walking clubs. Walking club leaders learn about the medical and physical implications of enrolling elders in a regular exercise program, and are certified upon completion of the training. Registered club members receive Keep Moving Membership Certificates, Walking Manuals and Passbooks and are encouraged to make personal and group walks part of their life styles.

A regular program of walking can help to prevent or to control many major health problems: coronary heart disease, hypertension, diabetes, anxiety, depression, arthritis, osteoporosis, and obesity. A brisk walking routine can be particularly helpful to people concerned about shedding those extra pounds. For example, 100 extra calories a day can result in a 10-pound weight gain. These extra calories can be burned up by a 15- to 20-minute walk each day.

Walking tones muscles that would otherwise become soft and flabby and improves balance and agility, lessening the likelihood of injuries from falls and accidents. Getting outside for a walk in all seasons and all kinds of weather can reestablish contact with the rhythms of nature or the sights and sounds of city streets. Walking can improve self-image, relieve tensions, and most important, it feels good.

Why group walks? Most of us, no matter what our age, are not self-motivated to exercise and need the structure of a planned program. The need for movement certainly does not diminish with age but the desire and options unfortunately do. By organizing community walks, the walking clubs establish a regular routine and motivation. Walks with companions also provide a very valuable time for sharing and socializing.

The annual Governor's Cup is the highlight event of the Keep Moving program. Walking clubs throughout the Commonwealth rally together for a day of fun, friends and fitness. Some 3,000 older athletes from Massachusetts were joined by competitors from New Hampshire, Rhode Island, Virginia and San Francisco to celebrate their fitness in the 1985 Governor's Cup 1-mile fun walk, 3-mile competitive walk, or 5-mile run.

Sports and media personalities joined Governor Dukakis at the event. Setting the pace for the 5-mile run were senior marathoners, Johnny Kelly, 78, and Ruth Rothfarb, 84. Former Boston Bruins star and celebrity chairperson, Bobby Orr, was cheered as he led spirited elders on a 1-mile walk around the Boston Public Garden.

Regardless of the race or the pace, everyone received Governor's Cup medallions as they crossed the finish line. The Governor's cup is awarded to the first place male and female finishers in eight age categories from 40 to 75 and older.

Right now, walking club members throughout Massachusetts are walking and training for this year's Governor's Cup Walk and Run which will start on Boston Common at noon on Sunday, September 21st.

The Keep Moving program has received major funding from Nabisco Brands, Inc., Rockport Company, and Blue Cross/Blue Shield of Massachusetts. Additional grants were received from Raytheon Company and the Boston Globe Foundation.

Massachusetts residents interested in learning more about the program or starting their own walking club should contact Penny Carver at (617) 727-4092, or write: Keep Moving, Executive Office of Elder Affairs, 38 Chauncy Street, Boston, Mass. 02111.

Massachusetts Secretary of Elder Affairs Richard Rowland with 84-year-old marathon runner Ruth Rothfarb.

"My Legs Are Tired As the Devil!"

The instructors of the "Come Alive at 65" physical fitness and exercise course at Louisiana Tech University in Ruston probably get more positive feedback from their students than any of the other teachers on campus.

"I couldn't bend to tie my shoes when I started this class, but now I can do real well," says Mr. T. He and his fellow senior students have been exposed to a systematic and progressive sequence of exercises in a program that offers swimming, walking or jogging, isotonic exercise, aerobic dance, and mild workouts in the weight room.

Mrs. A. claims "the class has helped my arthritis more than any other medicine." The only bad thing about this class, says one woman, is "it ruins our hairdos." And the best thing, explains another participant, "It keeps you healthy. You don't get sick and you find out how many bushels of peas Ethel's been shelling."

The "Come Alive at 65" fitness program was initiated by the Health and Physical Education Department at Louisiana Tech in the fall of 1978. The class was part of a response to a statewide program that allows residents who have reached age 65 to enroll in state-supported colleges for a one-time $5.00 application fee.

The older adult is considered a full-time student able to take any undergraduate course offered. Classes, which are taken for credit, have ranged from flute to sculpture to engineering, with the "Come Alive" course the only one restricted to students 65 or older. Participants in the fitness program are required to have a medical examination and show proof of age before they enroll.

The isotonic exercises are designed to strengthen and tone the muscles and improve or maintain joint mobility. Modified to suit the capabilities of the older adult, these exercises are used each class period for 30 minutes.

Louisiana Tech University's physical fitness course for older adults.

The tempo is slower than it would be for a younger person, and the repetitions are increased at a slower rate, but definite progress is soon evidenced by the participants.

Aerobic dances, modified for seniors to exclude the fast, bouncy, jumping movements, lead to improvements in coordination, balance, stamina and rhythm. Swimming is particularly popular, with the arthritics in the group especially vocal concerning the benefits of water exercises. Exercising in the pool is done using pre-recorded oral commands, with lively music in the background.

Muscle toning and strength is the concentration in the weight room, where the novelty of the special equipment relieves the monotony that often develops with this kind of exercise. Slow jogging or brisk walking, another key part of the program, helps to keep blood vessels elastic, improves circulation and tones and strengthens leg muscles.

The social aspects of the course are also a big plus with one member observing, "So many of us (over 65) have no outside interests . . . this program really helps."

As for the physical capacities of some people in this age group, Mr. P. who is 65, uses them to the utmost. He jogs six miles five days a week and works out daily in the weight room.

The class has grown from an initial enrollment of 18 in 1978 to 250 students in the fall of 1985, with the age of the participants going as high as 85.

The participants in this program mean business. They take the exercises very seriously. Faces fill with concentration as flutter boards sweep through the water, and the instructor in almost drill sergeant fashion barks, "Turn! One, two, three . . . strut! Don't save yourself for the Calypso!"

"I ain't savin' myself for nothing," one member protests. "My legs are tired as the devil." Yet, she perseveres.

For further information, contact: Dr. James B. Akers, Professor, Health and Physical Education Department, Louisiana Tech University, P.O. Box 3176, Tech Sta., La. 71272.

(This article was written by Dr. James B. Akers, Professor in the Health and Physical Education Department at Louisiana Tech University and Dr. Buddy Lyle, Associate Professor in the Adult Education Department at the University of Arkansas in Fayetteville.)

Nutrition Training For Case Managers Working With the Homebound

Public programs which provide aid for the homebound elderly have grown rapidly in the past few years. They can provide an alternative to costly nursing home care and offer practical and emotional assistance to frail older adults living on their own.

Although home-delivered meals and homemaker services to help prepare food are often included in programs for the homebound, most service delivery systems do not pay much attention to the many and varied factors which may cause nutrition problems for the frail elderly.

Diet plays an important role in the development and treatment of many of the elderly's common health problems, including obesity, heart disease, diabetes, and hypertension. Lack of a varied and healthy diet may worsen existing health problems or delay the recovery from illness. Also, the frail elderly may have trouble preparing and eating food because of dental, vision, or arthritis problems. And the lack of transportation, inadequate income, isolation, and limited cooking ability make it even more difficult for homebound older adults to obtain adequate nutrition.

Most programs that provide services for homebound elderly adults don't have the luxury of having a nutritionist or nutrition educator routinely go along with service management staff on home visits. Yet these case managers, usually social workers, are the "front-line" workers who can recognize nutritional needs and help to resolve them through direct action or referral. Because of this situation, the In-Home Services Program of the Philadelphia Corporation for Aging (PCA) offered two 4-hour training workshops on nutrition for its service management staff.

The goals of the workshops were to increase the social workers' awareness, knowledge, skills, and resources to recognize and deal with nutritional problems among their homebound clients.

The workshops included a variety of teaching methods: lecture-discussion, small group activities, case studies, and audiovisual presentations. Six main topics were covered: (1) attitudes about nutrition and the elderly; (2) introductory personal nutrition; (3) an overview of nutrition for older people; (4) therapeutic diets; (5) food safety; and (6) ways of identifying and meeting clients' nutritional needs.

In order to allow as much time as possible for the participants to be actively involved in the workshop sessions, a resource packet of informational materials was provided at the beginning of each session. The packets contained existing printed educational materials about workshop topics and outlines of lecture information. They also included information about exercises for the homebound, food-drug interactions, shopping for food bargains, and how to find and select useful nutrition education resources.

After the training sessions, a follow-up meeting was held with caseworkers, supervisors, In-Home Program Administrators, the PCA Nutrition Program Specialist, and the trainer. With a training program such as this, it is important for the skills, and resources from time-limited workshops to be integrated into the ongoing service program.

Although PCA is not repeating these workshops at present, the resource packet materials and workshop agendas are available for the cost of reproduction and mailing ($15), and consultation on replicating these training workshops is also available. For further information about the nutrition training workshops for social workers working with the homebound elderly, contact Karen Glanz, Ph.D., M.P.H., Associate Professor, Department of Health Education, Temple University, Philadelphia, PA. 19122 (215) 787-5109.

Health Screening Van Solves Access Problems For Rural Pa. Elderly

Access to adequate health care was a major problem in the 1970's for 60,000 elderly living in a rural, hilly area of Southwestern Pennsylvania, a region characterized by scattered small communities, unemployment, poverty, and few public transportation services.

In fact, two of the three counties served by the Southwestern Pennsylvania Area Agency on Aging (AAA) were ranked as the second and third most medically underserved in Pennsylvania. Due to lack of primary medical and dental care facilities, most elderly residents were not inclined to seek health care until their symptoms became severe.

The Area Agency staff determined that the solution to these problems was a mobile screening service, a preventive health care program that would be flexible, comprehensive and affordable to the elderly. Such a program would also require support and promotion by each of the communities served and a systematized referral protocol linked to other care providers in the three-county area. The Agency purchased a 35-foot van, designed and equipped to provide health screening, that could travel even to the most remote mountain areas.

In order to assure professional support, the Agency established a contract with a physicians' corporation and provided a series of briefings on the project to local medical societies and other health care providers. The AAA also developed an information and referral system that included not only its existing senior service subcon-

tractors but also numerous community organizations located in rural towns across the Planning and Service Area.

This program has now served the elderly in Southwestern Pennsylvania for the past 12 years. The staff includes a program supervisor, registered nurse clinician, community organizer, medical social worker, physician consultant, dental consultant, and laboratory technician. Volunteers organize appointments in the nearly 100 communities the program serves, assist in conducting the health screenings, and provide lunch and recreation at screening locations. Approximately 20 persons per day receive an annual screening in each community within the service area.

Volunteers from the towns publicize the annual screening, take care of dates and locations, solicit participants, and arrange transportation to the site through the AAA when needed. Each patient is pre-scheduled for an individual appointment with the nurse clinician and other unit staff. Other volunteers who travel with the van provide lunch, recreation and information about other AAA-sponsored programs.

Each elderly person receives a multi-phasic screening and consultation. The screening program consists of: intake (health history and completion of other health forms); urinalysis and vital statistics; vision, tonometry and hearing testing; blood pressure and other health tests (eg. pap smear, breast exam, hemoccult test); oral cancer screening; EKG when requested; and review of health history and screening results.

All abnormal test findings are mailed to the elderly persons' family physician, who makes the decision regarding further evaluation or treatment.

Since the screening program was implemented, 30% of all patients screened have been referred for further medical evaluation or treatment based on abnormalities identified in the screenings. Although some abnormalities were consistent with disorders the patients already knew about, 3.2% of the abnormalities (representing 227 people) were first-time detections—in many cases, conditions that could have developed into critical health problems.

The mobile health screening program has been accepted enthusiastically by the elderly in Southwestern Pennsylvania. Beyond its value in detecting health problems, the program has prompted 2,000 persons per year to follow a preventive approach to health care. Furthermore, the program's comprehensive referral system has helped the elderly to gain access to other types of services that residence in remote rural areas often prevented them from using. As a result, the program has retained the strong support of the elderly and their advocates in Southwestern Pennsylvania for more than a decade.

(This article was written by Donald H. Goughler, Holly S. Lange and Diane Broggi of the Southwestern Pennsylvania Area Agency on Aging, Inc. in Monessen, Pennsylvania. Tel. (412) 684-9000.)

The health screening van visits over 100 communities, with volunteers in each town scheduling appointments.

AoA-Supported Health Promotion Publications

Copies of these publications will be available in the fall of 1986 and may be obtained by writing to: The National Center for Health Promotion for Older People, National Council on the Aging, 600 Maryland Ave., S.W. West Wing 100, Washington, D.C. 20024 (202) 479-1200. A small fee will be charged for each publication to cover the cost of postage and handling.

Compendium of Health Promotion-Related Initiatives for Older Americans. This compendium of projects developed by national voluntary organizations highlights the four areas emphasized in the AoA/PHS National Health Promotion Campaign—injury control, nutrition, physical fitness and appropriate drug use. Each project description includes information on collaborating agencies, project setting, materials available, and the appropriate person to contact. Also included are other types of projects related to health promotion, such as health screening, patient education, and respite care. The organizations sponsoring the projects range from national associations of optometrists and dental hygienists to the National Council of Catholic Women. The guide was compiled by Lorraine N. Ross of the National Voluntary Organizations for Independent Living for the Aging. (NVOILA).

A Resource Guide for Injury Control Programs for Older Persons. The first section is a general discussion of injury control programming for the elderly, and the second discusses community organization and utilization of community resources. The last three sections identify operational steps in implementing a *home safety audit* (training of volunteers), a *community safety audit* (pedestrian safety, safety on public transportation, senior escort service, etc.) and *exercise and fitness programs for injury prevention.* At the end of each section, materials have been included for reproduction and use in local injury control programs. Throughout the guide, suggestions are made for reference materials and organizations that can provide further information. The guide was prepared by Leah Dible, Alan Pardini, and Marjorie Bogaert-Tullis of the Aging Health Policy Center at the University of California in San Francisco.

Health Promotion and Aging—A National Directory of Selected Programs. This directory presents descriptions of over 50 programs ranging from statewide efforts to activities sponsored by county health departments, public school districts, hospitals and Area Agencies on Aging. The projects fall into five major categories—comprehensive health promotion programs and programs focused on injury prevention, nutrition, physical fitness and safe use of medications. Each project description includes information on the sponsoring agency, staff, annual budget and materials available. The directory was prepared by Stephanie J. FallCreek, Beverly P. Allen, and Delores M. Halls of the Institute for Gerontological Research and Education at New Mexico State University for the Aging Health Policy Center at the University of California in San Francisco.

A Resource Guide for Nutrition Management Programs for Older Persons. The guide contains chapters on nutrition management programming for seniors; development of community resources; supermarket demonstrations (presentations on nutrition and food shopping conducted at local supermarkets); development of a cookbook for seniors which can be used by consumers and nutrition centers; and a basic cooking class series designed to educate the elderly to improve their nutrition. The end of

each section includes resource materials that can be duplicated for use in local programs and listings of additional helpful books and resources. The publication was written by Marjorie Bogaert-Tullis and Sarah Samuels of the Aging Health Policy Center at the University of California in San Francisco.

A Resource Guide for Drug Management Programs for Older Persons. Also prepared by Marjorie Bogaert-Tullis (see previous publication), this guide presents a general discussion of drug therapy for the elderly and covers patterns of drug use by older Americans, drug management programs, the development of drug education classes, and use of personal medication records for seniors. The appendices list resources for program development, including pharmaceutical associations, schools of pharmacy and departments of consumer affairs in the various states.

Health Promotion for Older Persons: A Selected Annotated Bibliography. The bibliography includes pamphlets and books on health promotion, exercise, nutrition, mental health, injury control, drug management, health promotion program development, and health conditions in old age. It was prepared by Alan Pardini and Deborah Lerner of the Aging Health Policy Center at the University of California in San Francisco.

Health Promotion and Aging: Strategies for Action. The first section of the guide, which is on how to build coalitions, describes the public and private agencies that make up the aging, health, recreation, and education networks. Diagrams help to sort out the various bureaucratic layers at the federal, regional, state, area, and local levels. The second section of the guide describes eight program models, including Hypertension Screening With Black Elders and a Community Media Health Awareness Campaign. The last section discusses the challenges and pitfalls of developing community-based health promotion programs for older people. The guide was prepared by Stephanie FallCreek and Pat Franks, consultants to the Aging Health Policy Center at the University of California in San Francisco.

In addition, the following book may be purchased from The Haworth Press.

A Healthy Old Age: A Sourcebook for Health Promotion with Older Adults. By Stephanie FallCreek and Molly Metler. Published by The Haworth Press, Inc., 28 East 22nd St., New York, N.Y. 10010. Hardcover, $32.95, plus $2 postage and handling. The book covers health promotion planning, activities and resources. Chapters include Wellness in Old Age, Program Development Guidelines, Changing Life Style, Tips for Facilitators, Stress Management, Nutrition, Physical Fitness, and References (a comprehensive bibliography covering the variety of subjects in the book).

Nutrition Education for Ethnic/Minority Elderly: A Manual. Contact Borinquen Lugton, Administration on Aging, Region II, 26 Federal Plaza, New York, NY 10278. (212) 264-4591 or Elizabeth W. McMath, Erie County Office on Aging, Nutrition Program for the Elderly, Rm. 1376, 95 Franklin St., Buffalo, NY 14202. (716) 846-7639.

Nutrition Education for Ethnic/Minority Elderly: A Manual provides lesson plans based on educational objectives and includes chapters on how to relate the eating habits of specific ethnic/minority groups to good nutritional practices. The specific ethnic/minority groups addressed are Black (including Southern and Carribean), Hispanic, Jewish, Asian American, and Native Americans.

The Manual includes sections on Basic Nutrition, Purchase and Preparation of Food, Food Information and Misinformation, Food Safety, and Weight Control. The Manual provides detailed information on equipment needed, teaching materials, handouts, charts, and other resources. The chapters on each of the specific ethnic/minority groups show what each group needs to learn, given its dietary habits, and further provides exercises for the instructor to use in getting the new information across to the ethnic/minority older person.

Stand Tall! The Informed Woman's Guide to Preventing Osteoporosis. By Dr. Morris Notelovitz and Marsha Ware. Triad Publishing Co., P. O. Box 13096, Gainesville, FL. 32604. (904) 373-5308. Hardcover $12.95, paperback $6.95.

Stand Tall! is geared to young and middle-aged women who wish to prevent osteoporosis as well as to postmenopausal women who need to halt further bone loss. Authors Dr. Morris Notelovitz and Ms. Marshal Ware have compiled the latest research results on the preventive benefits of nutrition, exercise, calcium, and hormone replacement therapy. They emphasize that while the disfiguring symptoms of osteoporosis rarely appear before the age of 60, a woman's risk is largely predetermined by diet and life style from the time she is a young adult.

Notelovitz and Ware explain that around the ages of 30 to 35, women reach their greatest, or "peak," bone mass, after which they begin to lose

more bone than is replenished. After menopause, women lose bone at an accelerated rate due to a calcium deficiency that is triggered by the abrupt decline in the body's production of estrogen.

Stand Tall! emphasizes the importance of maintaining high enough levels of calcium in the diet to offset the substances and factors that prevent absorption or increase excretion of calcium. Among the 'calcium robbers' discussed are excessive protein, salt, coffee, fasting, stress, excess Vitamin A or D, cola drinks and processed foods with phosphorus additives. The authors recommend daily consumption of 850-1000 mg. of calcium before menopause and 1200-1400 mg. during and after menopause, in contrast to the American woman's average consumption of 450 mg. daily.

Nutrition for the Prime of Your Life. By Annette B. Natow Ph. D, R.D., and Jo-Ann Heslin, M.A. R.D., McGraw-Hill Book Co. 1221 Avenue of the Americas, New York, NY, 10020. (212) 512-2486. $8.95

Questions most often asked by mature Americans about nutrition are answered in *Nutrition for the Prime of Your Life.* The authors combine folk wisdom with the latest scientific research regarding cancer and nutrition, stress, weight loss, drugs, depression, headaches and living longer. There is a special chapter for women and appendices on junk food and food additives. The question and answer format, in addition to questionnaires, recipes, tables and charts, all help the reader to improve the quality of his or her life through better knowledge of nutrition.

Dr. Natow and Ms. Heslin are professors of nutrition at Adelphi University, registered dieticians and partners in a nutritional consulting firm. Both are active clinicians in nutritional areas relating to cancer, women, and the elderly.

Carol Fraser Fisk, Acting Commissioner on Aging, presents a Wellness Year Round Calendar to U.S. Surgeon General C. Everett Koop.

Planning a Wellness Program? Make It A Year-Round Event!

Now you can plan 12 months of health promotion programs with the National Council on Aging's WELLNESS YEAR ROUND PLANNING CALENDAR, a display-size (11½ x 27") beauty that combines practical information, program and activity ideas with beautiful color photographs of older persons celebrating and practicing good health.

Developed by NVOILA—NCOA's National Voluntary Organizations for Independent Living for the Aging—with support from the U.S. Administration on Aging and Campbell Soup Company's Institute for Health and Fitness, the calendar was designed to help you bring a wellness orientation to your program.

To assist group program planners and managers to incorporate year-round health promotion activities in existing services, the calendar provides suggestions for developing new wellness activities and programs for older persons in their communities. The calendar can serve as a planning tool as well as a learning resource for lay and professional leaders in health programs, and for older citizens, too.

Each month introduces a new theme, such as safety, nutrition, exercise, prevention of cardiovascular disease, mental health and dental care, presenting facts and myths about the topic and guidelines for improving health. Programming ideas are offered that are appropriate for individuals, groups and communities. The calendar ends with a section listing over 120 organizations that can serve as resources for developing wellness activities.

The WELLNESS YEAR ROUND CALENDAR is a terrific way of making 1986 or any year the beginning of a fresh commitment to good health. Copies are available from the National Council on the Aging, Publications Department, 600 Maryland Ave., S.W., West Wing 100, Washington, D. C. 20024. Single copies are $5 each; 2-10 copies, $3 each; 11-100 copies, $2.50 each; and more than 100 copies, $2 each.

HEALTH AND WELLNESS FILMS

Health. Cancer. Heart Attack. Woody Clark Productions, 743 Howard St., San Francisco, CA. 94103. (415) 777-1668. Sale: 16MM, $500 each; video, $300 each. These three 25-minute shorts, entitled "Health," "Cancer," and "Heart Attack," are based on "The Healing Force," a feature-length documentary of Norman Cousins' battle with two life-threatening illnesses. In the three shorts, Mr. Cousins uses humor, positive thinking, and personal responsibility to regain his health.

Be Well: Physical Fitness in the Later Years. The 23-minute video presents health information for older people, using real-life experiences, advice from authorities, and dramatic vignettes. Describes different exercise programs, offers cautions, and suggests motivations. Contact Churchill Films, 662 N. Robertson Blvd., Los Angeles, CA. 90060 (213) 657-5110. Rental, $40. Sale, $450.

Staying Well. This 27-minute video uses interviews to dramatize key steps to healthier life styles through physical fitness, better nutrition, and stress management. Participants and experts give motivation to change life styles. Distributed by Blue Cross and Blue Shield, 676 N. St. Clair St., Chicago, IL. 60611. (312) 440-5660. Rental, $35. Sale, $445. English and Spanish.

General Foot Care. (Podiatry: Keeping People on Their Feet Series.) In this 13-minute video, viewers learn there are over 50 ailments that can affect feet and how to avoid many of them. Brochure accompanies video. Coronet Health Care Education, 65 E.S. Water St., Chicago, IL. 60601. (312) 940-1268. Sale, $270.

For a Change: Breaking Old Habits and Making New Ones. An instructional film featuring people who improved their health by changing their habits. They used systematic behavioral approaches to stop smoking, begin exercising or lose weight. Shows that permanent change is possible. Contact Spectrum Films, Inc., 2755 Jefferson St., Carlsbad, CA. 92008 (619) 434-6191. Rental, $65. Sale, $485.

Staying Active: Wellness After 60. In this film, Dr. Walter Bortz presents the message that good health does not just happen; you have to make it happen. The film focuses on eating properly, relaxation, adapting to major life changes, building strength and flexibility through exercise, and feeling good about yourself by staying involved. Gives profiles of people in their 60's, 70's and 80's who are leading active lives. Contact Spectrum Films (see film immediately above for address). Rental, $65. Sale, $495.

Burn Wise. This 18-minute instructional drama takes the viewer on a home tour, pointing out potential fire and burn hazards. Explains preventive measures and demonstrates proper first aid to use in event of burn injury. Distributed by The New York Hospital, 525 E. 68th St., New York, NY. 10021. (212) 472-6890. Sale: 16MM film, $250; video cassette, $150.

Aging in Action. The 28-minute video and manual presents a practical guide on how to design fitness classes for the relatively fit to the non-ambulatory older adult. The five components of each exercise class are illustrated, together with four different levels of intensity and difficulty. *Aging in Action* is made for those teaching or working in the field of exercise and older adults. Education Department, Baycrest Centre for Geriatric Care, 3560 Bathurst St., North York, Ontario, Canada M6A 2Ea. (416) 789-5131, Ext. 216 or 468. Sale: U.S. residents, $150.

The following films and videos are available from Kinetic, 255 Delaware Ave., Suite 340, Buffalo, NY. 14202 (716) 856-7631.

You Haven't Lived Yet. 25-minutes, color. Sale: 16 MM, $510; video, $410. An inspirational film that presents excerpts from a lecture entitled "The Splendid Old," delivered by Dr. John Brantner of the University of Minnesota. The film, which includes interviews with happy people from 70 to 100, points to the great variety of physical, mental, spiritual and emotional capacities that can make fulfillment possible within the human aging process.

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Opening Creative Doors for the Homebound

In Memory of Herman Brotman

Herman Brotman, a long-time leader and pioneer in the field of aging, and personal friend, died on June 15 at the age of 77. Herman devoted over a half century of his life to preparing and supporting studies and legislation that have brought vital improvements to the lives of older Americans. In fact, Herman grew and matured along with the field. He was only 26 when he began work on research materials for what ultimately became the Social Security Act.

After serving in the U.S. Army during World War II in Austria and receiving the Army's Meritorious Civilian Service Award, Mr. Brotman returned home in 1952. He once again became involved in the field of aging, working on special studies and joining the Special Staff on Aging in the Office of the Secretary of the then Department of Health, Education, and Welfare.

When the Administration on Aging was established, Mr. Brotman joined the staff and eventually became Chief of the Data Analysis Division and later a Special Assistant to the Commissioner of AoA. During these years, he helped to draft the original legislation that later became the Older Americans Act, the first comprehensive piece of legislation creating agencies and programs in every State to provide a range of services to older Americans. During these years, Mr. Brotman also produced a wealth of publications and statistical studies which helped to form the basic literature for students and professionals in the field of gerontology.

After retiring from Federal service in 1973, Mr. Brotman continued his involvement in the field, as a consultant to the Senate and House Committees on Aging and several major research companies. He also served on the boards of many of the organizations in the field of aging and lectured at universities across the country.

It is difficult to gauge a man's life in a few paragraphs of print. While our professional accomplishments certainly reflect who and what we are, to our friends and loved ones we are far more. In summing up his life, I would like to cite some of the many comments that our nation's leaders have made about Herman Brotman.

On the occasion of his 70th birthday, Senator John Heinz wrote, "In Japan certain long-lived persons are designated 'National Treasures.' If we had such an honor you would undoubtedly be one of its recipients. You can be very proud of your contribution to improving the quality of life for older Americans. Through your generous contributions toward enhancing the lives of the elderly, you have also helped to maintain the dreams of young Americans who can look forward to their later years as a time of dignity and meaningful activity."

When Herman died, Representative Edward R. Roybal wrote into the *Congressional Record* that Herman "was a warm, generous, and hospitable person who had an insatiable zest for life. Although Mr. Brotman is known for his many accomplishments, he is often remembered for the little things such as taking vegetables from his garden to the nearby shelter and accompanying frail senior citizens to vote."

And Representative Mario Biaggi wrote in the *Record*, "Herman Brotman was a remarkable man in many ways. His background was one that spoke of an intense desire to help the aging in our society, but his personal qualifications were what made him so loved and admired."

Herman was both a professional mentor and a personal friend to me. Our friendship began in Northern Virginia in the early 1970's and expanded when I became Acting Commissioner on Aging. Herman was always there to offer support and wisdom. My work and my life will continue to be influenced by his vision of a nation committed to a better and more secure life for its oldest citizens.

All of us who knew Herman Brotman will miss a valued colleague and a beloved friend. None, I know, will miss him more than Sylvia, his loving wife and companion of 52 years. Sylvia has established a most fitting tribute to Herman—one that will continue to have a positive impact on the lives of older Americans for generations to come.

She has been joined by some of Herman's colleagues in setting up The Herman B. Brotman Fund for Gerontology Students at George Mason University in Fairfax, Virginia where Herman was a guest lecturer in recent years. I know that many of you who read *Aging* magazine were Herman's friends and colleagues and that you will want to join me in helping to support this worthy tribute to his memory.

Carol Fraser Fisk
Commissioner on Aging

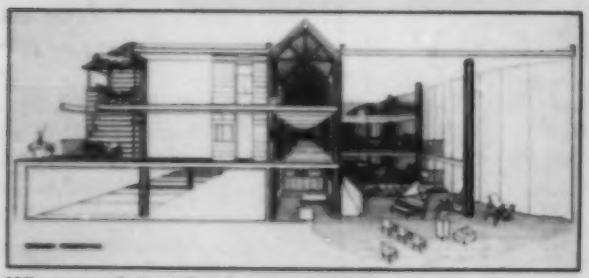
Those wishing to contribute should make their checks payable to the George Mason University Foundation, Inc., noting on the memo line of the check that the contribution is "For the Herman B. Brotman Fund." The checks should be sent to Sylvia Brotman at 3108 Holmes Run Road, Falls Church, VA 22042.

Aging

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration on Aging

Award-winning TV show informs older Nebraskans about services. 10

On the Cover is a photo of one of the cloth banners designed by the homebound elderly in the Artworks program in San Francisco. Artists on the project staff transport the banners from one home to the next where each elderly person adds to the design. Program volunteers sew into place the compositional elements that the artists and the homebound pin onto the cloth backing. Entered into a city-wide art show, several of these eye-catching "Elderbanners" took first prize. *See Story on page 2.*



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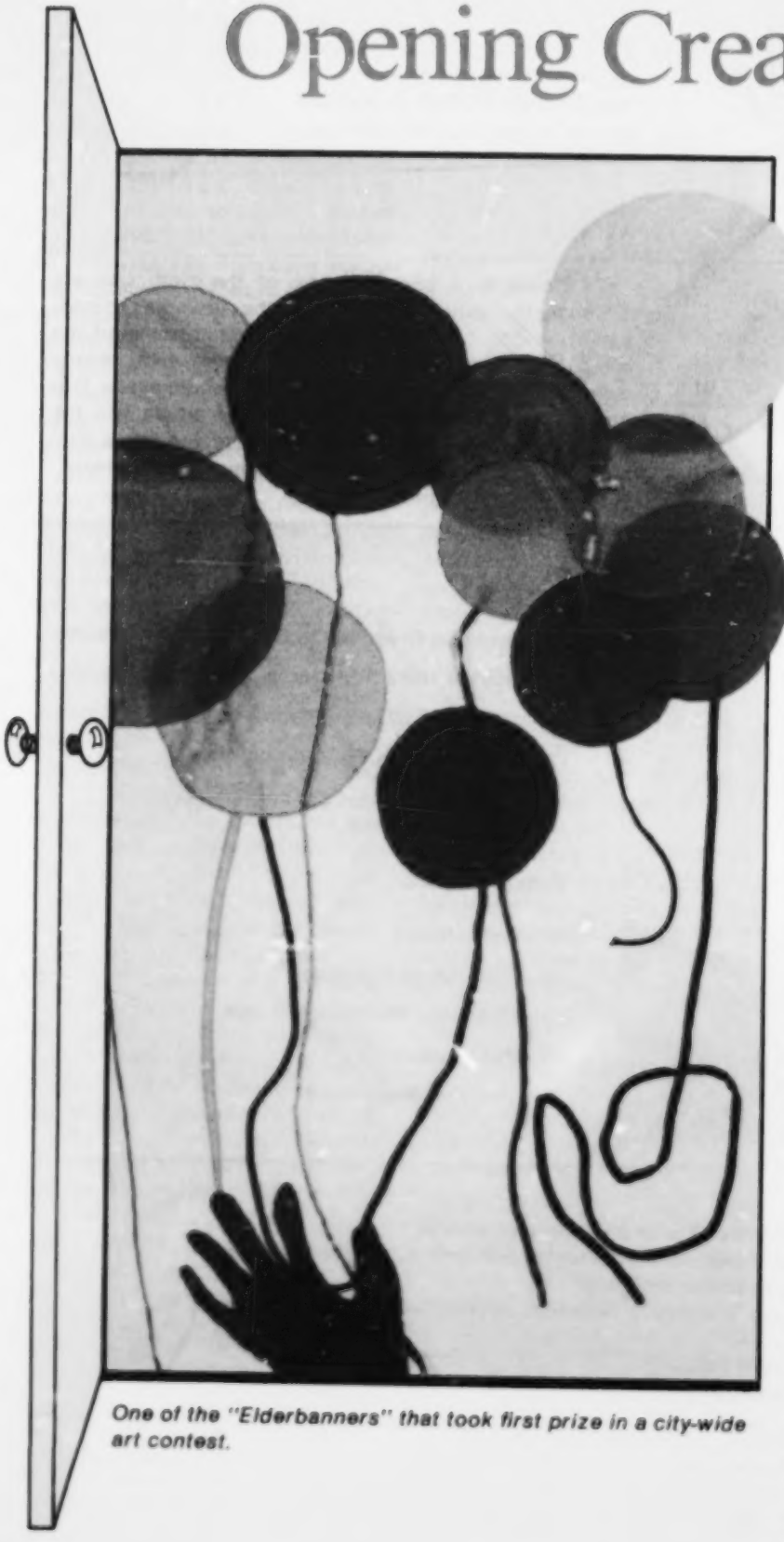
Opening Creative Doors

San Francisco Artworks program sends artists into the homes of the ill and disabled elderly

by Sheila Stavish



One of the "Elderbanners" that took first prize in a city-wide art contest.

A first-of-its-kind program in San Francisco is providing the homebound elderly with "attending artists" who make weekly house calls for individual tutoring in creative pursuits.

Artworks, now in its seventh year, is sponsored by Mount Zion Hospital and Medical Center, a private nonprofit acute care facility noted for its community geriatric services. The program is funded by several sources, including the San Francisco Commission on the Aging; Mount Zion oncologist, Jay Gershow, MD; the California Arts Council; and the National Endowment for the Arts.

The idea for Artworks came from the hospital's home care staff who had seen patients' progress decline because of the stressful effects of boredom and depression. Involvement in an absorbing activity promised to provide some recreation, an emotional outlet, and a sense of satisfaction and accomplishment.

Established in 1979, the program offers weekly visits to homebound patients by a staff of professional artists who work with each client on individually-tailored projects. Until recently, clients could continue with

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s for the Homebound

Photo by Mikkel Aaland

A homebound Artworks client rediscovers her artistic talents with the help of weekly visits from artist Cynthia Grace.

the program indefinitely; a burgeoning waiting list, however, led to the decision to limit an individual's participation to 12 weeks per year. With a staff of five artists, this rationing plan accommodates about 200 participants each year, with waiting-list time cut to about three weeks.

Maureen Kellen-Taylor, an artist who coordinated Artworks until recently, commented on the program's impact in an interview last year: "Often, we come in after the physical therapy or nursing services have been completed and we find people who are managing okay physically, but their spirit is gone. They have unknowingly committed themselves to death long before they are ready to die."

"Being artists," she continued, "we have an intensity and passion for what we are doing that's contagious. We can say to these people, 'You are more than your disease; more than your disability. You matter!' Helping them find an activity they will enjoy enough to convince them we're right is an immense challenge."

She said that watching one stroke patient progress from drawing crude representations of household objects to executing subtlely shaded abstract watercolors was exhilarating proof that patients can meet the challenge.

Art Builds on Interests

A unique feature of Artworks—and one of the reasons for its popularity and success—is the staff's attempt to build projects around the individual's interests. Because most participants haven't tried their hands at arts and crafts since their elementary school days, they don't have a clear notion of what sort of project to pursue.

The program's current coordinator, Robert Rice, makes an initial home visit to get to know clients, looking for clues as to what might appeal to them. For an individual with fond memories of traveling, for example, he might suggest a collage devoted to that theme. When staff artist Michelle Shelfer discovered another client's beloved collection of buttons, she helped the woman incorporate them into wall hangings. As a first step in establishing rapport with another client, Ms. Shelfer brought in arresting photos of the woman's native country.

Hands busy over a lifetime are the subject of this arresting banner, also featured on the cover.

As an art medium, a collage is a good first project, says Ms. Shelfer. Designing a collage allows the individual to express imagination without intimidating the hesitant beginner, and it's an activity that can be geared to differing physical limitations. For a collage-assembler who can wield a pair of scissors, Ms. Shelfer simply brings a stack of magazines or other materials. Working with a bedbound patient recovering from a stroke, however, she provides the client with precut materials from which to choose.

Seemingly no disability is beyond the resourcefulness of the staff. For a woman whose failing eyesight had forced her to give up the drawing she enjoyed, artist Cynthia Grace found an alternative medium: vivid acrylic paints applied in bold patterns. These were done on rice paper and hung over an ailing relative's windows to give a stained glass effect while blocking the view of a dingy street. For a quadriplegic, artist Leonard Breger created a canvas that allowed the man to design by dictation—a grid with numbered coordinates to which Breger, serving as the client's hands, applied color at the client's direction.

Banners, A Group Project

A popular current project involves collaboration among homebound clients, through the artists, in designing huge mural-like cloth banners. Mounted on poles, the banners are rolled up and transported from one participant's home to the next for working sessions. A group of well elderly women who volunteer at the program do "postproduction work," sewing into place the compositional elements that client and artist pin on the cloth backing.

Entered into a city-wide art show, an assemblage of several of these eye-catching banners took first prize. The Artworks staff then presented each participant with a facsimile of the blue ribbon, along with a snapshot of the displayed work. These banners are both a source of pride to their creators and a way of focusing community attention on the needs and abilities of the homebound elderly.

Projects in the visual arts are not the only pursuits in Artworks. Some clients are working on oral histories, recording their memoirs on tape. Others are writing a musical drama, also a group effort, led by Michelle Shelfer, a professional songwriter and folksinger as well as visual artist. That project was sparked by the interests of one of the collaborators, who used to work in the theater. The text and musical score will be written by the clients, and Ms. Shelfer envisions staging the work at board and care homes, with residents as the players.

Open to any homebound San Franciscan over 60, Artworks serves people who are diverse in background and sophistication. But the one-on-one arrangement accommodates all levels of artistic ambition. As one of his projects, for example, a retired architect created the art for the program's brochure. The artists' encouragement has led others to go back to painting or other creative hobbies abandoned long ago.

Each homebound person adds an element to the design of the Elderbanners.

Funding and Structure

While funding permitted a full-time coordinator for the first four years, the job now has to get done in an "official" 22 hours per week. In addition to fundraising, the coordinator documents the program's accomplishments for grants-makers, supervises the artists, and makes assessment visits. Four artists, also salaried, each put in 14 hours per week.

Though recruiting artists is no problem—at least in San Francisco—former coordinator Maureen Kellen-Taylor believes that a program like Artworks would not be feasible with an all-volunteer staff. "It's assumed that artists are willing to work for the love of it," she says, "but monetary compensation shows them they're as valued as any other professional and prevents burnout" in a job that requires a very high level of commitment.

Artworks' small budget for supplies is supplemented with in-kind donations—occasionally of the white-elephant variety. "Part of the job is figuring out what to do with some of the unusual things the artists are given" says Mrs. Kellen-Taylor. Wallpaper remnants bestowed by a local contractor, for instance, turned out to make good backings for collages. But the staff is still pondering possible uses for thousands of zippers and buttons. As for soliciting donations from art supply stores, Mrs. Kellen-Taylor says others have gotten there first. "The art stores here are saturated with requests for donations, but in other cities, they would be useful resources."

Association with a hospital is a particular advantage for a program like Artworks, Mrs. Kellen-Taylor points out. The availability of medical consultation is helpful, and when an artist from the hospital arrives on their doorsteps, clients get a strong message that says "creative activity is good for you."

In addition to the home component of Artworks, the artists also work with Mount Zion inpatients and run 10-week group sessions at board and care homes, training staff to carry on the programs. Other services include providing follow-up visits at home for cancer patients of all ages; lunchtime concerts for hospital patients, employees, and visitors; creative activity groups for ambulatory patients in the hospital; and artwork to brighten otherwise bare walls in the hospital and offices.

Jay Gershow, MD, who supports Artworks financially, calls the program "tremendous therapy," both emotional and physical. "For the many participants with functional limitations due to arthritis or stroke, handicrafts help to improve manual dexterity," he says. And for the many clients who live alone, the program often provides their only social contact.

For some of the artists, the work has added a new dimension to their art. "Because we've worked with many people who have vision loss, I've learned to think in terms of materials that can be felt as well as seen," comments Mrs. Kellen-Taylor. "I have come to understand the creative process better and have enormous confidence in its powers . . . My clients were also my friends. They showed me that we all come to a point in our lives where we stop and look back . . . ."

For more information about Artworks, contact Robert Rice, Artworks, Mount Zion Hospital and Medical Center, P.O. Box 7921, San Francisco, CA, 94120. ■

Over 2,000 seniors turned out for the long-term care insurance forum.

Seattle HMO Adds Long-Term Care Services

by Mark Stensager

A Senior Caucus in an HMO motivates respite, case management and I&R Services

Senior citizens are a rapidly growing segment of the health care market, and an increasing number of hospitals and health maintenance organizations (HMO's) are developing a wide range of programs to meet their special needs. Among HMO's, Group Health Cooperative of Puget Sound is emerging as a leader in the development of long-term care services.

Mark Stensager is Director of Senior and Social Programs at Group Health Cooperative of Puget Sound and former director of the Seattle-King County Area Agency on Aging.

Formed in 1947, Group Health Cooperative (GHC) is one of the oldest HMO's and the fourth largest in the United States. It currently has 330,000 enrollees, 33,000 of whom are Medicare age.

Recent years have seen a dramatic rise in the number of HMO's due to the passage in 1973 of the Federal HMO Act, which was designed to stimulate their growth, and to increasing competition in health care. HMO's have several distinguishing characteristics. They generally provide a comprehensive set of benefits for a single monthly payment and usually require enrollees to use specified facilities and physicians.

At Group Health, elderly members are entitled to full Medicare coverage and pay an additional monthly standard plan premium of $33.90 or a high option plan premium of $54.35. The standard plan covers only Medicare benefits, deductibles and co-payments. The high option plan, which reflects the basic benefit package of the Cooperative, augments Medicare coverage with routine physicals, eye exams, immunizations, outpatient drugs, unlimited hospital days, and other GHC benefits. Services are provided in Group Health's two hospitals and 23 clinics in the Puget Sound area. Members are able to choose a personal physician from

Photo by Kim Zumwalt

among 229 primary care physicians who work for Group Health.

Group Health has had a special "risk contract" with Medicare for the past 10 years. Under this arrangement, the Government makes a yearly estimated payment to GHC based on the costs of serving Medicare enrollees in the Cooperative. The government also calculates the average per capita costs of serving Medicare recipients in the Seattle area. If GHC is able to serve Medicare enrollees at a lower cost through efficient operations of the HMO, savings of up to 20% of Medicare's estimated annual payment are split 50-50 between Medicare and GHC. Savings in excess of 20% are retained entirely by the Federal Government.

Group Health recently estimated that good preventive services and cost-efficient operations had reduced Medicare costs by $42 million between October 1976 and the end of 1985. Half of that has gone back to the federal government and the other half has been reinvested in the Group Health program to expand services.

The Senior Initiative

In 1983, a Senior Caucus was formed in Group Health, made up of older consumers, many of whom had been active in establishing GHC in the late 1940's. "We created the Caucus to be assured that this successful HMO would meet our needs in our later years," said Dr. Charles Strother, one of the organizers. The Senior Caucus called for the development of a variety of health promotion and long-term care programs, and GHC's Board of Trustees responded by creating a "Senior Initiative" to develop wellness, chore, respite, case management and other needed services.

Another compelling reason for starting the Senior Initiative was to improve the management of geriatric acute care services at GHC. As Medicare reimbursement policies have grown more restrictive, health care organizations have been forced to operate more efficiently by avoiding unnecessary hospitalization and by moving patients out of the hospital in a more timely fashion. This requires high quality home care services and solid relationships with nursing homes, both of which were of interest to GHC to improve geriatric care and increase efficiency.

The third motivation behind the Initiative was market position. Americans aged 65 and over account for more than 30% of the nation's health care expenditures and 39% of short-term hospital stays (Med. Econ., April 19, 1985, p. 42). With increased competitive pressures, providers of health care have come to realize the importance of the older adult market.

Dr. Carol Austin, Associate Director of the Senior Initiative, comments, however, that "of all the forces behind the Senior Initiative, the Senior Caucus has clearly been the most important in shaping the scope of this program." In recent months, several of the programs that the Senior Caucus recommended have been organized by GHC.

Volunteer Respite Services

One of the most successful is a volunteer respite and chore assistance program. Today, more than 140 volunteers have been recruited to provide relief to burdened caregivers and to assist with household chores, laundry, socialization, transportation and grocery shopping. Administrator Kathy Francis describes this service as "that little bit of assistance that can make the difference between being at home and being in an institution."

Ms. Francis came to Group Health in the spring of 1985 after organizing

Photo by Geoff Manasse/ Photography

Volunteer Sam Molen staffs the Senior Information Line, referring members to services at Group Health and in the community.

a very successful volunteer respite care program in a community south of Seattle. At Group Health, she uses a variety of approaches to recruit volunteers—eye-catching flyers, posters, press releases, spreading the word to health care providers, and presentations.

Volunteers are asked to attend a 6-hour training workshop and may receive specific training depending on their assignment. The volunteers are grouped by 10 geographic areas, with a volunteer coordinator assigned to each area to call volunteers once a month to update information on their availability. The coordinators are also in the process of learning from Kathy Francis how to take on some of management's responsibility for matching volunteers with appropriate clients.

"Being involved with your community is a normal healthy thing to do," comments volunteer Sigrid Myrdal, a scientist and a mother of three. "I have strong feelings communities should take care of themselves and not depend on fee-for-service agencies for everything. I think being needed is as important as eating or sleeping."

On her way home from work, Ms. Myrdal stops by the home of Esther Chen, 76, to visit and take her shopping. Mrs. Chen doesn't drive and pains in her legs make walking long distances difficult. "The added benefit is that I really like Mrs. Chen," says Mrs. Myrdal. "I think we're becoming good friends."

I & R and Case Management

In cooperation with the Seattle-King County Area Agency on Aging, another new program was started for older GHC consumers in the fall of 1985, a telephone service called the "Senior Information Line." This program is also staffed by volunteers who have been carefully recruited and trained to assist GHC enrollees and their families with locating resources within GHC and in the community. The Area Agency on Aging (AAA) helped to train the volunteers and to develop the resource index of community services, and callers are often referred to the AAA for various types of services.

The line receives about 100 calls a week, ranging from simple inquiries to much more complex requests. The caller may need information on transportation or in-home services or may want to voice some fears and concerns. The Senior Information Line hopes to expand this year to make weekly reassurance calls to people who live alone or whose spouse has recently died.

The Senior Initiative staff have also developed a case management project targeted at moderately impaired older adults living at home who are at risk of either hospital or nursing home admission. Referrals are made by the primary care physicians to a "case coordinator" at one of the GHC clinics, who makes an in-home assessment of needs and arranges for community-based services. Eventually, the program will be in place at several clinics.

Michael Johnson, the project manager, says, "This program is designed to help people and at the same time reduce inappropriate use of the hospital and clinic services. One of our goals is to make better use of various community-based, long-term care services."

One typical example of a case Michael is working on now is a 77-year-old woman whose husband has Alzheimer's disease. At the time of her referral, she was a heavy user of her primary care physician because she was having difficulty coping with caring for her husband and didn't know where else to turn. Her husband needed total supervision 24 hours a day, and his condition was getting worse.

After Michael conducted the initial in-home assessment, he connected her with a respite care volunteer so she could get out of the house to do the shopping, run errands, etc. He also got her involved in an Alzheimer's support group. Another service he linked her to is Group Health's Mental Health Services. Staff there are providing her with counseling in various areas, such as financial planning and practical advice for handling her husband's behavior. They are also preparing her for behavioral changes in her husband as the disease progresses.

Michael is now looking at facilities where the woman's husband might be placed for a 1- to 2-week period to provide her with relief. He calls her every two weeks to see how she is doing and to make sure that she's connecting with the services he has arranged. She also calls him whenever she has a concern. Michael feels that his job is to coordinate the activities of the service providers and to make sure that each provider is aware of all the others involved.

Long-Term Care Insurance

In this past year, the Senior Initiative staff and the Senior Caucus have devoted a great deal of time to developing a long-term care insurance program for GHC enrollees that would cover nursing home and home care expenses not reimbursed by Medicare.

The Senior Initiative began this effort in July of 1985 with an education program for enrollees that explained the limits of Medicare and Group Health coverage and educated seniors on how to select a long-term care policy. The Senior Initiative staff was overwhelmed by the response. Approximately 2,500 people attended the forum.

Senior Initiative staff and the Senior Caucus had developed a *Long-Term Care Insurance Buyer's Guide* which was distributed to those attending the forum. This guide explains Medicare and Group Health coverage, the type of coverage available through long-term care insurance and how to evaluate the quality of individual policies.

Readers of the *Guide* find out, for example, that while Medicare covers some proportion of up to 100 days of skilled nursing home care, because of various restrictions, the average user of nursing home benefits receives only 27 days of covered care per year. Readers also learn that Medicare won't pay for intermediate or custodial care in a nursing home, and that coverage for in-home care is restricted to medical services.

The booklet also notes that in order to become eligible in the State of Washington for Medicaid—the biggest payment source for nursing home care—residents must have a limited income and no more than $1,500 in assets (savings, cash from the sale of their home, etc.). As in many other states, patients often have to spend their assets on nursing home care before they can receive Medicaid support. The booklet points out, however, that in the State of Washington, patients may transfer their assets to a spouse (but to no other relative) in order to become Medicaid-eligible. (Copies of the guide may be obtained by writing to the address listed at the end of the article.)

Based on the response to the forum and the *Guide*, Group Health moved to develop a long-term care insurance program. The HMO devised a model plan that would include coverage of skilled, intermediate and custodial nursing home care as well as a broad range of community-based home care services. Under the plan, benefits to GRC enrollees would be authorized and coordinated through a case management system. Group Health plans to finance this program in a partnership with Metropolitan Life, headquartered in New York City.

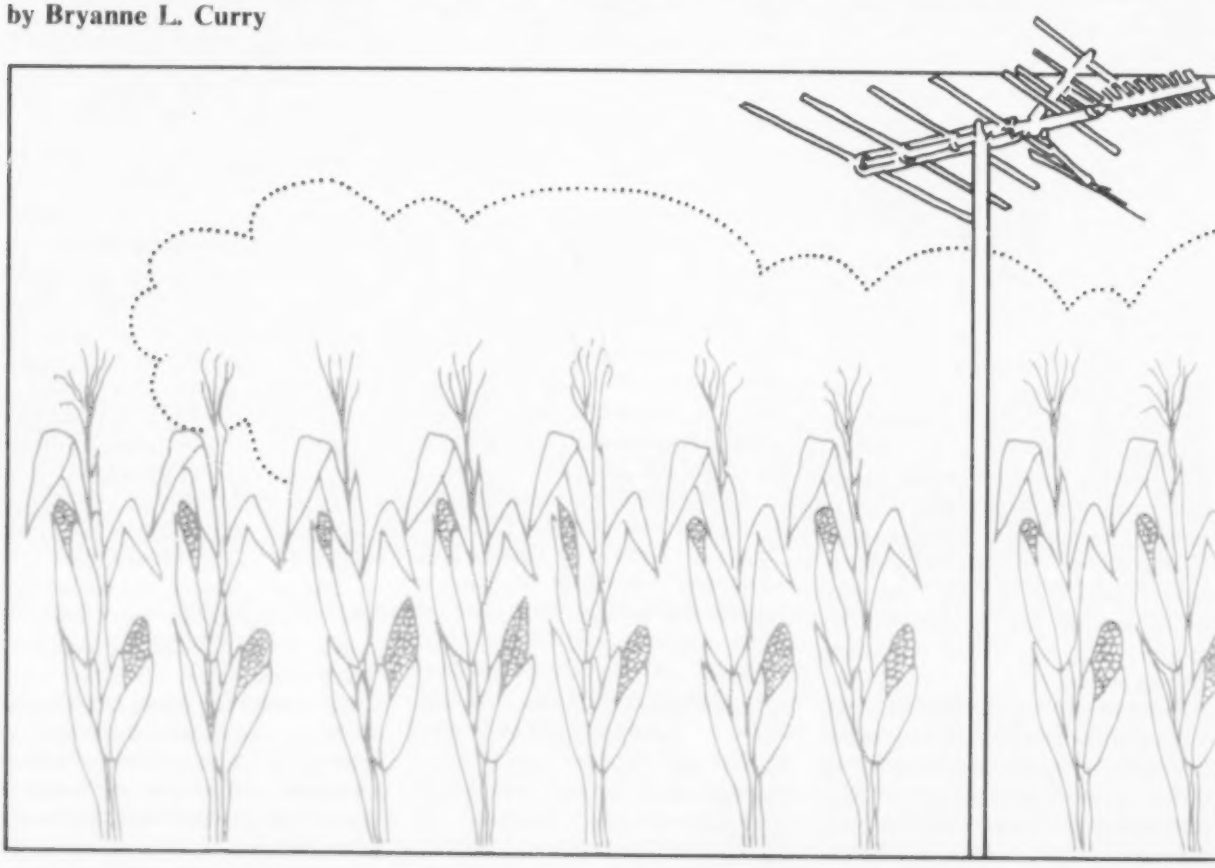
The development and marketing of the insurance plan will become the main focus of the Senior Initiative in the months ahead. GHC hopes to be able to offer the policy by the fall of 1986 to approximately 4,000 enrollees in a pilot project. The Senior Initiative staff is also exploring the possibility of establishing a Preferred Provider Organization of top quality nursing homes in conjunction with long-term care coverage. This arrangement would give participants discounted rates from selected nursing homes.

In its first 18 months, the Senior Initiative at Group Health has taken a number of major steps to enhance the delivery of health care to older adults. The Cooperative is becoming a leader in what will inevitably be a major trend in health care organizations throughout the country.

To obtain a copy of the *Long-Term Care Buyer's Guide*, send $3.00 to Senior Initiative, Group Health Cooperative, 221 1st Avenue West, Seattle, Wash. 98119.

Nebraska ETV's
"Grand Generations"

by Bryanne L. Curry



Let me say from the beginning I have never been objective about my responsibilities as producer of a weekly television series for and about older Nebraskans. What's more, I never really *intended* to be objective about the series. Do not be shocked. I know the first rule of journalism is objectivity. But I am a granddaughter before a journalist, and along with guiding my upbringing for 26 years, my dear Grandmother also taught me that age is no barrier *or* big deal. And so it was against that backdrop of comfort and familiarity with aging issues that in 1983 I assumed responsibility for "Grand Generations," a 10-year veteran of the Nebraska ETV Network's broadcast schedule.

I perceived the objectives for this series in the same way I perceived my Grandmother's objectives for her own life style in old age. As I watched and assisted my "Gram" in her struggle to stay in the home she loved and where she felt most comfortable, I was compelled to translate that struggle into television segments geared toward exploring programs and services available statewide to facilitate goals of independence.

In addition to that most important goal, the half-hour programs seek to foster a positive self-image for older Nebraskans. Program objectives are effected through "magazine" stories on such topics as wellness, consumer issues, history, personalities, transportation, housing, grief, Social Security, employment, and health.

Bryanne L. Curry is the Producer and Director of "Grand Generations."

Bryanne Curry works with series host Phil Heckman

Viewers Learn About Services

Prior to the 1986 season, "Grand Generations" was funded, in part, by a grant from the Nebraska Department on Aging. Because of the state's size and because, in many cases, communities are separated by long distances, the sharing of ideas concerning community projects became critical in stimulating the growth of comprehensive services for the elderly. A close relationship between "Grand Generations" and the Department on Aging (more specifically, the Area Agencies on Aging) developed, so that working in concert, we are able to inform older individuals about a plethora of services and projects from one end of Nebraska to the other—all designed to help them with specific problems.

Area Agency directors, who know their localities well, also help us to find Nebraskans who have interesting life styles, or *real* people to interview who are experiencing *real* problems, such as poverty or lack of transportation in rural areas. It is clearly more effective for us to illustrate the latter with a story about the difficulties involved when "Mary of Smalltown, Nebraska" tries to find a ride to the county seat for medical attention, than it is for us to interview an "expert" in the studio about the "problems of rural transportation."

In addition to "Grand Generations" role as informant, advocate, and image-builder, the series is an important referral system. More than 150 letters are typically received each month from viewers seeking further information about topics introduced on the programs.

We are able to help viewers find additional assistance in solving problems through a system created by "Grand Generations" staff. That system, which relies on the cooperation of numerous social service agencies, volunteer centers and consumer information groups, allows us to help people find answers to specific questions about programs and services such as Social Security, Medicare, supplemental insurance and high utility bills. We can also direct people to agencies that can help them find in-home services or deal with boredom, loneliness and other problems facing older people.

Intergenerational Appeal

The series has another important goal. It was first suggested several years ago by the Director of Nebraska's Department on Aging, Helen Boosalis. She requested that "Grand Generations" shift its focus

through a subtle appeal to viewers of all ages.

I looked again to my Grandmother for guidance in effecting this needed change. I began by observing the extra-special relationship between Gram and my preschool daughter. Over 80 years separated them and neither seemed abashed by the age disparity. In fact, Gram's mission to *maintain* independence, and my daughter's to *attain* the same seemed to spark a mutual admiration between them. It occurred to me that I was taking for granted the benefits of having an older person as an integral part of my life.

Intergenerational segments began to appear with regularity each season on "Grand Generations." They *always* carry the message that people are happier when they maintain contact with others from *all* age groups. We also initiated informative segments targeted at younger viewers as if to say: "If you intend to age, do not let it take you by surprise. Learn about these issues *you* may face as a result of your own aging."

70,000 Tune In

A word here about numbers seems appropriate. A formal study of the "Grand Generations" audience was completed in 1983 by the Gerontology Program at the University of Nebraska-Omaha. The study found that of the 348,000 persons in the state over the age of 55, 20.1 percent of them (nearly 70,000) watch "Grand Generations."

Since the study, the series has garnered much recognition. In 1983, "Grand Generations" was presented with a national writing award from the National Arthritis Foundation. In conjunction with the presentation of a 4-part series about arthritis, "Grand Generations" volunteers set up workshops around the state so that people could gather at senior centers and other community facilities to watch the programs and to discuss them afterward with doctors and nurses recruited for that purpose. Six thousand persons attended.

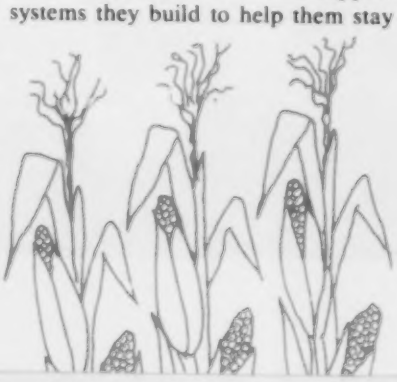
In 1984, the PBS series "Nova" purchased rights to air a program about the Nebraska-born inventor of the strobe light, Harold Edgerton. The program began as a "Grand Generations" segment, and was expanded when additional funding was made available from a private foundation in Dr. Edgerton's home town of Aurora, Nebraska. That program has won four national awards.

In May, 1985, the series received a prestigious national award from the Retirement Research Foundation of Chicago. I received the award on behalf of the series staff from Helen Hayes. And in November, 1985, "Grand Generations" received a national honorable mention award for target audience programming from the Corporation for Public Broadcasting of Washington, D.C. We are very proud of these honors. But we are even more pleased to have been able to offer a cost-effective means of delivering life-enhancing information to a very responsive audience.

After losing nearly two-thirds of our funding in the spring of 1985 as a result of state budget cuts, we were delighted when Mutual of Omaha decided to underwrite "Grand Generations." Although funding now comes from the private sector, we continue to work closely with the Department on Aging personnel and the Area Agencies.

From Legal Aid to Sexuality

The 1986 season proved to be an exciting one, as usual. We began in January with an hour special, featuring a one-act play performed by Omaha's Grande Olde Players. In the winter and spring, we presented magazines on such topics as "dependent" independents and the support systems they build to help them stay in their own homes; the difficult emotional and economic factors precipitating a decision to relocate to a nursing home; and the problems encountered in gaining access to high quality nursing home care. The season also included a program on learning and fun; another on nutrition and health; one on issues affecting older women; an exploration of depression as the springboard for a show about mental health; and a program on poverty.



Legal issues were explored, such as wills, power of attorney, and advertising for lawyers. Another broadcast was comprised solely of segments on intergenerational programs and activities around the state. There were also four live studio programs on such topics as Diagnosis Related Groupings, arthritis, Alzheimer's Disease, and problems facing older rural Nebraskans—shows in which viewers were invited to telephone in their questions to a panel of experts. An upcoming 1-hour special will focus on sexuality and aging.

As a result of "Grand Generations," older Nebraskans are able to see the efforts of their contemporaries in every corner of the state—to help make better lives for themselves and others through their coordinated efforts. The series helps reinforce the fact that retirement does not need to be a presage of senility, nonproductivity, boredom, depression, or even death.

"Grand Generations" helps inform elders about programs and activities designed to help maintain the most precious of all commodities—their independence. The series "singles out" older Nebraskans—as recipients of our respect, as recipients of information, as recipients for positive reinforcement to continue their quest for knowledge, mobility, independence, and pride in themselves and in the achievements of their peers. As my Gram once said to me: "In my mind's eye, I don't see myself as old. In my mind's eye, I'm the same as I always was." Through the eyes of "Grand Generations," we hope our viewers can feel the same! ■

Seniors Train to Serve Seniors

Most students at the U/Mass Gerontology Program are over 60

Photo by Hilda R. Schwartz

by Scott A. Bass

Solving the housing problems of the elderly in old neighborhoods hit by the renovation boom . . . helping to expand and improve home care services . . . investigating nursing home complaints—these are jobs that can make a real difference in the everyday lives of older Americans. These are also the types of new careers or volunteer commitments that students in their 60's and 70's are pursuing at the Gerontology Program at the University of Massachusetts in Boston.

"The Gerontology Program and Institute at the University of Massachusetts represents a new wave of institutions designed to harness the tremendous capacity of the able older person," comments Dr. Robert Morris, Professor Emeritus of Social Planning at Brandeis University and an internationally recognized expert on social policy. Started with funding from the Administration on Aging in 1979, the Gerontology Certificate Program at UMass/Boston was developed to prepare individuals over 60 to serve as professionals in the field of gerontology.

This career training program provides a two-term sequence in gerontology, the equivalent of 30 undergraduate credit hours, to students interested in doing direct care, administration, or policy work relating to the elderly. Although the program enrolls some younger people, the majority of the students are over 60, with the average age 67. The senior students receive a special tuition waiver from the state, and all students receive a State Certificate in Gerontology upon graduation.

The curriculum and assignments in gerontology are the same for both younger and older students at the college, but for many students who

Dr. Scott Bass is an Associate Professor and Director of the Gerontology Program and Gerontology Institute at the University of Massachusetts in Boston.

have not been in a classroom setting in 40 or 50 years, the experience can be difficult. Anna Harris, a 66-year-old student, commented, "It isn't easy going back to school, but I can't be a waitress the rest of my life. The Gerontology Program has provided me with an opportunity to change careers. The Program staff have provided me with so much help in going back to school." In fact, the Gerontology Program provides specialized support in reading, writing, and public speaking for its students as well as counseling and career placement services.

Commenting on the experience of returning to college, Charles Fraggos, a retired social worker with an MSW, remarks, "There is so much to learn in the Gerontology Program, but, you know, the Program also allows you to meet so many interesting people." Proof of the growing popularity of the program is the more than 200 inquiries received each year from potential students.

Admission is based on a commitment to do college-level work in gerontology, previous experience or personal interest in working with the elderly, external recommendations, and class diversity. The Program has two sections of 30 students each. Each section is carefully balanced to maximize diversity of student backgrounds, including students who have had no previous college education. One such student, Eva Rachin, 69, went on to earn her B.A. and has been hired by the Massachusetts Association of Older Americans, a statewide advocacy organization.

Influence on State Laws

Each year, gerontology students undertake a major applied research project concerning the elderly and their families. Over the past five years, each of these published studies has resulted in state legislation or a policy change. Evidence indicates that the quality of interviewing done by the older students in their research and their sensitivity to the issues affecting the elderly contribute immeasurably to the success of the studies.

Their first project was the publication of a study in 1981 on how older people were coping with the rising cost of fuel prices, a major problem in the Northeast. The research report helped to trigger a $22.5 million state appropriation for fuel assistance, targeted primarily to the elderly.

Other studies have examined client satisfaction with home care services, the quality of local nutrition programs for the elderly, the needs of families who care for their elderly at home, job satisfaction in home care corporations, and the experiences of families placing an elder in a nursing home.

The release of each of these studies has generated major press coverage, conferences to consider the problems identified by the studies, and the formation of coalitions to propose solutions and to negotiate with the Legislature for legislative and policy change. The studies have led to some impressive results, including a 10% one-year increase in State home care funds and a bill, expected to be approved, to give tax credits to middle- and low-income families who care for an elderly relative at home. One study also led to the forming of a coalition to work for guaranteed equal access to nursing homes for Medicaid patients competing with private-pay individuals. Another resulted in the earmarking of $500,000 in senior meals program funds for special outreach to two underserved groups—the ethnic elderly and homeless older people.

Different Career Goals

Some graduates of the Gerontology Program are quite interested in volunteer positions. Several are volunteer ombudsmen in nursing homes, some deliver meals to shut-ins, many are on the boards of agencies that serve the elderly, and some are friendly visitors in mental health or rehabilitation centers.

Other graduates want to enter the competitive job market and work full-time. The positions they have assumed have included case managers for home care agencies, administrators of programs for the homeless, and staff in adult day care programs. Several graduates are working in the Massachusetts Executive Office of Elder Affairs in such areas as elder abuse, monitoring of home care agencies, and training of Area Agency on Aging staff.

Most graduates, however, want part-time employment. Several agencies have been open to job-sharing possibilities for mature workers, but this is the exception rather than the rule. Although the Program learns of more job openings than there are graduates, the work is not always challenging enough or available on a part-time basis. With nearly 200 students over the past six years, the Gerontology Program has faced the problem of identifying significant part-time work for its graduates—particularly in the area of social policy.

Policy Positions

More opportunities for part-time policy work opened up in 1984 when the Massachusetts Legislature established the Gerontology Institute at UMass/Boston to further the work developed in the Gerontology Program. The Institute is a research and policy planning center. One of its missions is to promote significant roles for older people in conducting

Photo by Hilda R. Schwartz

A student confers with a professor during a coffee break.

applied research, influencing social policy, and in solving some of the major problems anticipated in an aging society.

Since 1984, the Institute has created a number of new programs to involve Gerontology Program graduates in more intensive education and training relating to state and local policy issues. Approximately 40% of the graduates of the Program have become involved in these activities. The new programs include:

■ **An Elder Policy Specialist Program.** This program is available to graduates of the Gerontology Program seeking to do advanced policy work. A team of locally and nationally recognized experts works with 6-8 Policy Specialists on a specific issue. The Policy Specialists commit two days a week to the effort for a period of a year and are paid a $500 honorarium. The issues studied so far have included legal services for the elderly, hospice care financing, and community housing for the elderly.

For example, this year in the housing group, eight policy specialists worked with two technical experts on the housing problems of older residents in urban neighborhoods undergoing "gentrification." The specialists and technical experts selected a specific neighborhood for study, worked with several community agencies in the neighborhood, developed a needs analysis instrument, conducted interviews with a sample of residents in the community, and provided the agencies with a technical review of the scope of the problem. This has all been provided at no cost to the community. Through this process, the specialists learn new skills and the community benefits from their analysis and recommendations.

■ **An Alumnae Program.** This is a competitive program administered jointly by the Institute and the Gerontology Program alumnae. Small grants are provided to six alumnae per year to investigate innovative ideas for use in the Boston area. Among the ideas explored are reminiscence groups in nursing homes and informal continuing education programs for seniors.

■ **An Emeriti Collaborative.** This program, only in its formative stage, involves retired, or soon-to-retire, faculty from universities and colleges in the Boston area in exploring ways to use their previous experience to perform public service in their retirement. Approximately 50 retired professors responding to a recent survey of area colleges and universities have indicated an interest in joining the program.

■ **The Minority Elder Coalition.** This separate nonprofit corporation represents 22 different community agencies concerned with the special problems of minority elders.

■ **A Pre-Retirement Training Program.** In cooperation with another state agency, the Institute has begun a state-wide pre-retirement training program for teachers 55 and over. The Institute's coordinator for this program is a graduate of the Gerontology Program.

■ **Conferences.** Each year, a major conference is held on an important issue facing our aging society. The topics addressed at these conferences, which attract as many as 300 older participants, are often linked to class research projects in the Gerontology Program.

Robert L. Turner, political columnist for the *Boston Globe*, summed up the efforts of the Program and Institute when he recently wrote, "The program has done revealing and often powerful research into the effectiveness of the fuel assistance program, housing for homeless elderly persons, the personal and family struggles involved in nursing home placements, the advisability of communal meals programs, and the effect of hospice treatment for the terminally ill."

In coming semesters, there will be many more issues to examine that will benefit from the substantial input of older students with years of life experience and a first-hand knowledge of the problems of senior citizens. By tapping the capabilities of older individuals, this nation can expand the resources and ideas that it will need to solve the problems of a graying America. ■

Leon Lenois is surrounded by his new family—Ruth Sterling and her two children Benjamin and Taiyo.

New Families for the Frail Elderly

Adult Foster Care in Franklin County, Mass.

by Pat Bradford and Albert Norman

Knowing that families are the greatest resource for providing long-term care to the elderly, the Commonwealth of Massachusetts has found a way to create family supports where none or few exist.

Since 1979, the "Adult Family Care" program has placed approximately 400 elders in new families across the state. Over the past six years, the adult foster care effort has grown from one demonstration project to 12 programs serving 75 percent of Massachusetts.

Pat Bradford is the Program Manager of Franklin County Home Care Corporation's Family Care project, and Albert Norman is the Executive Director of the Massachusetts Home Care Association.

One of these programs is located in rural Franklin County, an area of more than 900 square miles of thinly-populated western Massachusetts towns. Sponsored by the Franklin County Home Care Corporation, which both administers state Home Care services for the elderly and includes the Area Agency on Aging, the program is finding new homes and families for frail elders as an alternative to nursing home placement.

For Leon Lenois, a 67-year-old farmer with severe respiratory difficulties who had previously lived alone, Family Care has meant a new home on a farm owned by Jeff and Ruth Sterling in the town of Leverett. Although the rhythms of farming are familiar, Leon has found that, in other ways, his new environment is quite different. "My life has changed considerably in all ways from where I was," he comments, "because I don't have to sit alone anymore." Mr. Lenois tends 20 chickens,

takes part in the daily life of the family, and shares his knowledge of farming with the Sterlings, thus helping them to establish their farm.

For the Sterlings, the rewards are more than monetary. "Leon's presence adds to the feeling that our home is really a base, a center," says Ruth Sterling. "My son Ben missed the benefits of having an older person in his life—until Leon came."

Under the terms of their agreement, the Sterlings receive $17.50 a day for providing Leon with room, board and certain aspects of personal care. Since Leon is receiving Medicaid, the state pays $9.50 towards his daily care, and he pays the remaining $8 a day directly to the Sterlings.

The state also reimburses the program's sponsor, the Franklin County Home Care Corporation, for administrative costs and the salaries of the Family Care program's two staff members—a social worker/manager and a part-time registered nurse.

Elders participating in Family Care who do not receive Medicaid pay the full $17.50 a day—a sum considerably less than the daily cost of intermediate-level nursing home care. According to a recent study of adult foster care in Massachusetts conducted by PM Associates of Quincy, Mass., the financial side of Family Care is as attractive as the services side—not only for private pay participants but also for the state Medicaid program. The average daily cost to the state for assisting elders on Medicaid in Family Care is 37 percent lower than it would be to maintain them in a Level III nursing home.

Franklin County's program currently has 11 elders in new families. Although the program receives roughly five new referrals each month, some of them are not appropriate for Family Care. Sometimes, the health problems are too severe. In other cases, the elder and the relatives finally decide on nursing home placement because it's a more familiar concept than Family Care. The staff has found that for some families, it's easier to say that "Mom got sick and we had to put her in a nursing home" than it is to say, "Mom is living with the Joneses down the street." Attitudes, however, are changing and natural families are beginning to view Family Care as a very acceptable alternative to nursing home placement.

Finding willing families has not been an issue—with over 45 homes now on a "ready list" to accept an elder. While some participants require a considerable amount of custodial care, others are quite active. The PM Associates study of the Family Care population revealed that 10 percent of the placements move on to more independent life styles after a recuperative stay in the program.

Although nearly 40 percent of all participants have remained in Family Care for at least one year, the program can also serve to provide short-term respite for natural family caregivers who need residential 24-hour support for an elder in order to get a break from the stress of daily care.

Family Care is also expected to play an increasing role in post-discharge recuperative stays for elders leaving hospitals under the Diagnostic Related Groupings system, which only began in Massachusetts in October of 1985. Franklin County Home Care recently placed three elders with approved families for short-term recuperative stays to regain their strength in order to return to independent living.

When it was first established and caseload levels were low, the Franklin County program was dependent on start-up funds from the state's Executive Office of Elder Affairs (EOEA) and also received support from a private foundation, the Fred Wells Trust. This year, Family Care in Franklin County is expected to meet its operating costs solely with Medicaid and private-pay revenues.

Finding the Right Family

One of the chief roles of the program staff is to function as matchmakers. An elder's medical, psychological and emotional status—as well as any special needs or preferences for a style of home living—is assessed as part of the eligibility determination. The older person must have a doctor's approval to join the program, must be continent, oriented, able to transfer with minimal assistance, and be medication-controlled for all medical and psychological problems. Prospective families are also carefully assessed—for their interest and caregiving capacity as well as the strength of their own family relationships. Finally, the home itself must comply with standards for cleanliness, safety, comfort and accessibility for the elder.

Once the matchmaking starts, a series of short meetings and overnight visits are arranged and monitored by the staff. These meetings allow all parties to "try each other out" to see if the placement feels appropriate. Participants are matched with families for similarities in life style, personal preference and practical needs.

Before the elder stays for any length of time with the new family, the staff uses a brief care plan to teach family members about the elder's medical and social needs. If the elder and family agree to live together, staff arrange and facilitate the move, develop a more extensive care plan, and begin family training. Within three days of the relocation, Family Care staff visit to assess and assist in the adjustment process.

Weekly staff visits follow for six weeks, and then staff visit monthly for the duration of the placement. If the elder has natural family members, the staff encourages them to stay involved and visit often in the new setting.

respecting the privacy and schedule of the host family. Family members have access to 24-hour back-up assistance if a medical emergency or other situation arises that requires professional advice.

Less Isolated Lives

For many older people, participation in Family Care brings new social contacts and opportunities for recreation. Florence Alber, a 74-year-old single woman with severe arthritis, had spent her life caring for aging relatives, leaving little time for socializing or getting out to community events.

About a year ago, Miss Alber moved to the home of a couple with the remarkably appropriate name of Dennis and Beverly Welcome in the town of West Deerfield, close to her hometown. Several weeks later, Miss Alber attended the Franklin County Fair for the first time since 1948 where she renewed old acquaintances and surprised herself by winning a stuffed kitty on the midway.

Since then, she has also developed friends at the Elder Day Center which she attends twice a week. The rest of the time, Florence Alber likes to stay busy around the house, folding laundry and drying dishes, as her health permits. Beverly Welcome appreciates Florence's help and, in turn, assists Florence with her personal care.

"She's a member of the family," says Beverly Welcome. "My kids are grown and gone and the house seemed so empty before Florence came—I had no one to do things for. I love being home, so this has worked out great."

As for Miss Alber, she can't imagine living anywhere else. "I guess I've got myself a real family now."

In another town, Emma Elovirta has two 83-year-old women living with her, her husband, and their 6-year-old daughter. "I worked in a nursing home and have always been interested in the elderly," explains Emma. "I feel good about helping people. I want to make sure when I get old that there's a program like this to care for me."

To Betty Sweeley, who was in a nursing home before coming to live with the Elovirta's, "Family Care is wonderful. Beats a nursing home! Here, I'm more independent and can schedule my time the way I choose."

The other new member of the Elovirta household is Edna Bassett, a diabetic with Parkinson's disease who had been hospitalized with a compression fracture of the spine before she came into Family Care. "I had a fear of going into a nursing home," Edna admits. "So I felt 100 percent better knowing that I could go into Family Care . . . My new family gives me attention and is helping me to get stronger."

Family Care is getting stronger as a community care option in Massachusetts. Still a relatively small program compared to the state's 12-year-old "Home Care" system which provides in-home services to 44,000 elders each month, the Family Care concept enjoys the full support of the Executive Office of Elder Affairs and the Medicaid Division within the state's Department of Public Welfare.

"We're pleased that Family Care has gone so far," comments Richard H. Rowland, Secretary of the Executive Office of Elder Affairs. "We want to see Family Care cover 100 percent of the state. It's part of the continuum of long-term care in Massachusetts."

For further information on the Family Care Program in Massachusetts, write to: Jeanne Dionne, Executive Office of Elder Affairs, 38 Chauncy Street, Boston, Mass. 02111, or to Hazel Croy, Medicaid Division, Department of Public Welfare, 600 Washington St., Boston, Mass. 02111. ■

Mr. Lenois tends chickens on the Sterlings' farm.

Carol Fraser Fisk Confirmed As AoA Commissioner

Carol Fraser Fisk was confirmed as Commissioner on Aging by the United States Senate on August 9, 1986. Mrs. Fisk has served as Acting Commissioner on Aging since December 1984.

During her tenure at the Administration on Aging (AoA), Commissioner Fisk has placed major emphasis on the development of a truly responsive system of community-based services for older Americans in every locality, with the Area Agency on Aging playing the key leadership role in making this system a reality.

In speeches and meetings throughout the country, Commissioner Fisk has noted that in most communities, there are a number of separate service systems for the elderly operated by public agencies, religious and nonprofit groups, and private health care organizations, with little coordination to insure that the systems interact to provide what older people need. She has stressed that achieving this coordination is essential to making a wide range of services accessible to all older Americans, with emphasis on a continuum of care to help the frail elderly to maintain their independence.

Mrs. Fisk joined the U.S. Department of Health and Human Services in April 1981. She has served as Special Assistant to the Assistant Secretary for Human Development Services and as Director, Office of Regional Operations, in the Office of Human Development Services. She was a member of the United States Delegation to the United Nations World Assembly on Aging held in Vienna, Austria, in 1983.

Prior to her work with the Federal government, Mrs. Fisk served as Senior Research Associate in the aging program at the National Association of Counties in Washington, D.C. Her previous experience includes serving as planner for the North Virginia Areawide Model Planning project for the elderly in the early 1970's. She has also worked for the Northern Virginia Area Agency on Aging, the Arlington County Department of Human Resources in Virginia, and the United Way of the National Capitol Area, Arlington Chapter.

Mrs. Fisk received her Bachelors degree in 1968 from Connecticut College and her Masters in Urban and Regional Planning in 1972 from Virginia Polytechnic Institute and State University. She completed the Program for Senior Managers in Government at Harvard University.

New Manual on Needs of Elderly Euro-Americans

The Center for the Study of Pre-Retirement and Aging at The Catholic University of America recently published *The Euro-American Elderly in the United States: A Manual for Service Providers and Ethnic Leaders.* The manual describes strategies and model programs for addressing the social service needs of elderly Euro-Americans, who include nearly 40 ethnic groups.

Developed under a grant from the Administration on Aging and written by Christopher L. Hayes, former director of the Center, and his associates, the manual provides practical guidelines for the establishment of programs within ethnic communities for the estimated 7 million European aged who suffer from language barriers.

In Section I of the manual, which presents a profile of the Euro-American elderly, the authors point out that Euro-American immigrants are currently overrepresented among the age categories of "old" (65 to 84) and "old-old" (85 and older). Since many of these aged have maintained their original language, they have difficulty communicating in English in order to obtain needed social services.

The authors note: "Because they do not reach out for assistance, the Euro-American elderly, especially those who were left behind by their culturally and geographically mobile children, often find themselves isolated both physically and emotionally."

Drawing on information obtained from a national conference on Euro-American Elderly held at Catholic University on May 17-18, 1985, as well as from noted ethnic leaders and service providers, the manual makes a variety of critical recommendations for the development of services for this group. For example, since the Euro-American elderly often turn to their church, synagogue, or ethnic leaders in times of crisis, the authors describe the benefit of a collaborative effort between religious, ethnic, and public service institutions in providing culturally appropriate services.

Another important aspect of the manual is a step-by-step procedure that service providers and ethnic leaders can adopt in helping Euro-American families who are caring for an older parent. The authors point out that ethnicity can be a very powerful factor in how or whether a family or elder asks for assistance.

Service providers and ethnic leaders need to be aware of ways to address a person's ethnic/cultural/religious background so that assistance can be provided.

The manual also gives descriptions of innovative model projects around the country that are providing services to the Euro-American elderly. Among the innovative projects described are:

- an outreach program in Cleveland that utilizes older ethnic volunteers who identify Euro-American elderly living at or below the poverty level and refer them to appropriate services.
- a housing project for the Ukranian elderly in Warren, Michigan, which raised a combination of public and private monies to build a two-story residence for 146 elderly persons.
- an information and referral service within a Polish-American organization that provides assistance to 2,700 Polish-Americans per year in the city of Philadelphia.
- a senior nutrition program in Baltimore that specifically targets meals and services to the Euro-American elderly population.
- a national organization's project to educate mid-life and older ethnic women regarding planning for retirement.

Another important resource in the manual is recommended training outlines which can be used to sensitize social service staff to the unique needs of the Euro-American elderly. ***The Euro-American Elderly in the United States: A Manual for Service Providers and Ethnic Leaders*** is available for $8.00 by writing to Dr. Christopher L. Hayes, Long Island University, South Hampton Campus, Psychology Department, South Hampton, NY 11968.

HHS Report Raises Questions About Health Fair Screenings

A recent report from HHS's Office of Disease Prevention and Health Promotion (ODPHP) raises questions about the value of some screenings at health fairs at the same time that it acknowledges the importance of these fairs in educating citizens about ways to improve their health.

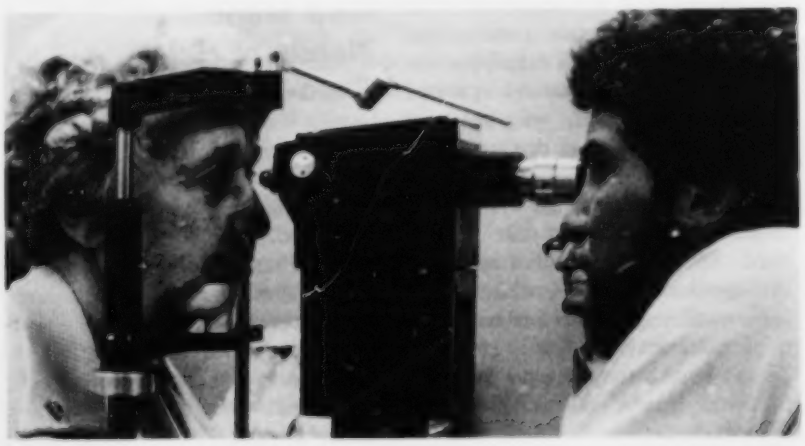
The report, *Screenings in Health Fairs: A Critical Review of Benefits, Risks and Costs*, was prepared for ODPHP by Dr. Donald M. Berwick, Associate Director of the Institute for Health Research at Harvard Community Health Plan in Boston.

"Major improvements in the rates of chronic illness in our population in the future are likely to depend less on what doctors do for people than on what people themselves do about their own health," Dr. Berwick comments in the report. From this viewpoint, he gives health fairs high marks for stimulating the interest of thousands of participants and volunteers in taking responsibility for their own health by stopping smoking, improving nutrition, and making other healthy life-style choices.

But with respect to health screenings, he notes that "without linkage to effective treatment, and without careful management of negative as well as positive results, screening for disease can be at best wasteful, and at worst actively harmful to the screened population."

Dr. Berwick maintains that four of the tests typically offered at health fairs—anemia, hearing, blood chemistry and glaucoma testing—have high rates of "false alarms from positive results, equivocal benefits from early detection of subclinical disease, and hazards of false reassurance from negative results." He stresses that health fair screeners need to be sensitive to the potential cost and psychological harm of both types of errors—false positives and false negatives—as well as to the harm of testing for conditions that can not be ameliorated.

In his 53-page report, Dr. Berwick examines the objectives, activities, and consequences of health fair screenings and evaluates their benefits and costs. Using basic epidemiologic and statistical principles, he reviewed the records of more than 20 health fair projects coordinated by the National Health Screening Council for Volunteer Or-



ganizations, Inc. and analyzed several common screenings—those for blood pressure, anemia, multiphasic blood chemistries, glaucoma, hearing, and occult blood in the stool.

Dr. J. Michael McGinnis, Director of the Office of Disease Prevention and Health Promotion states in an introduction to the report that "even though the screening at health fairs is very popular, it is not the most defensible component on substantive disease prevention grounds." In addition to noting that the population at greatest risk for the conditions being screened is often not that reached at health fairs, Dr. McGinnis asserts that only five of the tests commonly offered are justified according to accepted screening criteria: weight and/or skin fold thickness; blood pressure measurements; test of stool for occult blood for those over 50; and serum cholesterol and serum glucose determinations.

In a letter accompanying the report, ODPHP states that "the results of this study are important because health fairs are growing in popularity, and they provide health professionals both a unique opportunity to inform communities about controllable health risks and an obligation to take a hard look at their utility in the delivery of screening services."

Single copies of *Screening in Health Fairs: A Critical Review of Benefits, Risks, and Costs* can be obtained from ODPHP, Health Information Center, by calling the toll-free number (800) 336-4797 (in Washington, D.C. (202) 429-9091).

"Advice," A Newsletter For Family Caregivers

ADVICE—for Adults with Aging Parents or a Dependent Spouse, a new publication, will focus on helping caregivers maximize the independence of their aging relatives while minimizing their own stress.

The first issue (Feb.-March 1986) carried an article by U.S. Commissioner on Aging Carol Fraser Fisk—"Help Is Only A Call Away"—describing the role of 680 Area Agencies on Aging (AAA's) that serve the elderly and their families throughout the U.S. Commissioner Fisk stressed that "there are resources out there to help you and your aging parents or friends," and that the staff in the AAA's are available to provide "help in finding the assistance that best suits your situation."

In the June-July 1986 issue, Lorraine Liddoff, director of the National Council on the Aging's Family Caregiver Program, and Brina B. Melemed, who played a principal role in the National Long-Term Care Channeling Program, wrote "Caregivers and Case Managers: A Helpful Partnership." They describe the role of care managers (also known as case managers) in helping caregivers to reduce stress, find out about and connect with needed services and entitlement programs, and improve their home care skills.

The 14-member Editorial Advisory Board includes professionals in the aging field such as Rhonda Montgomery, Ph.D., deputy director of the Institute on Aging at the University of Washington in Seattle; Phyllis H. Mutschler, Ph.D. of the National Aging Policy Center on Income Maintenance at Brandeis University; and Dr. Barbara Silverstone, President of The Gerontological Society of America and Executive Director of the Lighthouse, the New York Association for the Blind.

The bi-monthly publication, which costs $14 a year, can be obtained by writing to Helping Publications, Inc., P. O. Box 339, Glenside, Pa., 19038.

Foot Care For Diabetics

According to Dr. Patricia Schultz, Washington, D.C. Podiatrist, Diabetes causes foot ailments indirectly. It causes the smallest arteries to lose their capacity to deliver blood to the tissues and results in a diminished capacity to fight infection by the white blood cells. The sensitive nerve endings and nerve trunks become dulled and the skin loses its ability to lubricate and heal itself. The bones begin to suffer excessively from gravity, weight and pressure, and the small muscles of the foot begin to lose strength.

Foot injuries in the diabetic patient often go unrecognized by the diabetic due to the loss of nerve sensation. Once the injury occurs, the lack of blood supply and poor infection response causes even simple problems to produce infections that heal slowly. Loss of limb is not automatic in diabetics if adequate preventive measures are taken.

For these reasons, according to Dr. Schultz, diabetics should follow these simple preventive measures.

- Examine the feet daily. If you cannot see your soles, use a mirror or ask someone to do this for you.
- Bathe or soak your feet daily in lukewarm water. Use a washcloth or small brush to reach between the toes with soap.
- Follow this with a good heavy duty moisturizer, such as cocoa butter or lanolin.
- Use cotton socks whenever possible.
- Have your shoes fitted carefully by a qualified shoe fitter. The diabetic foot without proper sensation cannot detect a poor fitting shoe. Abnormal pressure can lead to ulceration and infection.
- Never use hot water bottles, heating pads or hot soaks. Burns can lead to tragic loss of limb.

- Never attempt self-care of corns, calluses or difficult, ingrown nails. Acid-based corn drops are forbidden. Proper podiatric foot care at regular intervals is your best assurance of preventing infection and disability.
- Consult your physician or podiatrist at the first sign of:
  (a) isolated pain and redness or infection;
  (b) blisters;
  (c) ulcers—loss of skin cover, discolored calluses;
  (d) corns, calluses, ingrown nails;
  (e) thick deformed nails;
  (f) swelling after injury;
  (g) pus, drainage, or unusual foul odors despite cleansing.

AoA-Funded Project Creates Information Network on Elder Abuse

An up-to-date library of materials on elder abuse, a quarterly newsletter devoted to the problem, and new videotapes for training professionals to handle elder abuse and neglect cases are among the accomplishments of PROJECT IDEA. Funded by AoA in 1985, the goal of the project is precisely what its acronym stands for—Information Dissemination about Elder Abuse.

The project is being conducted by the University Center on Aging at the University of Massachusetts Medical Center in Worcester, Mass., with assistance from the American Public Welfare Association (APWA), the National Association of State Units on Aging (NASUA), and Intersection Associates, a consulting firm in Cambridge, Mass.

APWA and NASUA completed one of the first tasks on PROJECT IDEA's agenda—a survey between October and December 1985 of state laws and appropriations pertaining to elder abuse. The survey of elder abuse laws, one of the most comprehensive ever conducted, covered such factors as definitions of elder abuse and neglect, reporting and investigation procedures, penalties for perpetrators and professionals failing to report, protective services required for victims, and emergency intervention procedures. The survey was sent to all 50 states and U.S. jurisdictions.

APWA and NASUA are conducting a second survey to identify interagency organization at the state level to facilitate the detection and treatment of abuse and neglect as well as state efforts to educate the public about the problem.

A third survey, to be completed this fall by PROJECT IDEA, will identify existing training programs focused on elder abuse as well as the training needs of agencies in the fields of aging, mental health and protective services. As a first step toward meeting the training needs of service staff, PROJECT IDEA will distribute in the fall a series of three new videotapes, entitled *Elder Abuse: The Final Indignity—A Training Series on Abuse and Neglect in the Family*.

To insure the availability of current information on elder abuse and neglect, the project maintains a "Special Collection on Elder Abuse," a library that contains research reports, monographs and material on actions by state legislatures.

Information is also sent out regularly to administrators, service staff, and other interested professionals through *Elder Abuse Report*, PROJECT IDEA's quarterly newsletter. It now goes to over 3,000 organizations and state agencies concerned with aging, elder abuse, mental health, and legal and social services. The newsletter includes feature articles on innovative programs concerned with elder abuse and neglect; research findings; reports on conferences and pertinent publications; and descriptions of training programs and materials.

The first issue of *Elder Abuse Report* featured an article on "A Safe Place," a unique support group for elder abuse victims which is operated by Victim Services Agency in New York City. Describing the situations of some of the support group members, the article noted that one woman living with an abusive daughter bought a condominium to escape her predicament but then was afraid to make the change. Another wanted to ask for protection but was in-

timidated by the complicated legal procedures, and a third had repeatedly allowed her emotionally disturbed son to be discharged from a mental hospital to her home where he abused her.

By finally acknowledging their predicament, these women were able to get the group support they needed to change their situation. But many other abused or neglected elderly people remain silent out of fear or shame. This reluctance to self-report, coupled with the failure of professionals to detect elder abuse and neglect, has contributed to a complex problem that many experts believe is not receiving the national attention it deserves. According to one Congressional report, less than 5% of state budgets for protective services is allocated for assistance to elderly people who have been abused or neglected.

For further information about the various activities of PROJECT IDEA, contact: PROJECT IDEA, University Center on Aging, University of Massachusetts Medical Center, 55 Lake Avenue North, Worcester, Massachusetts 01605.

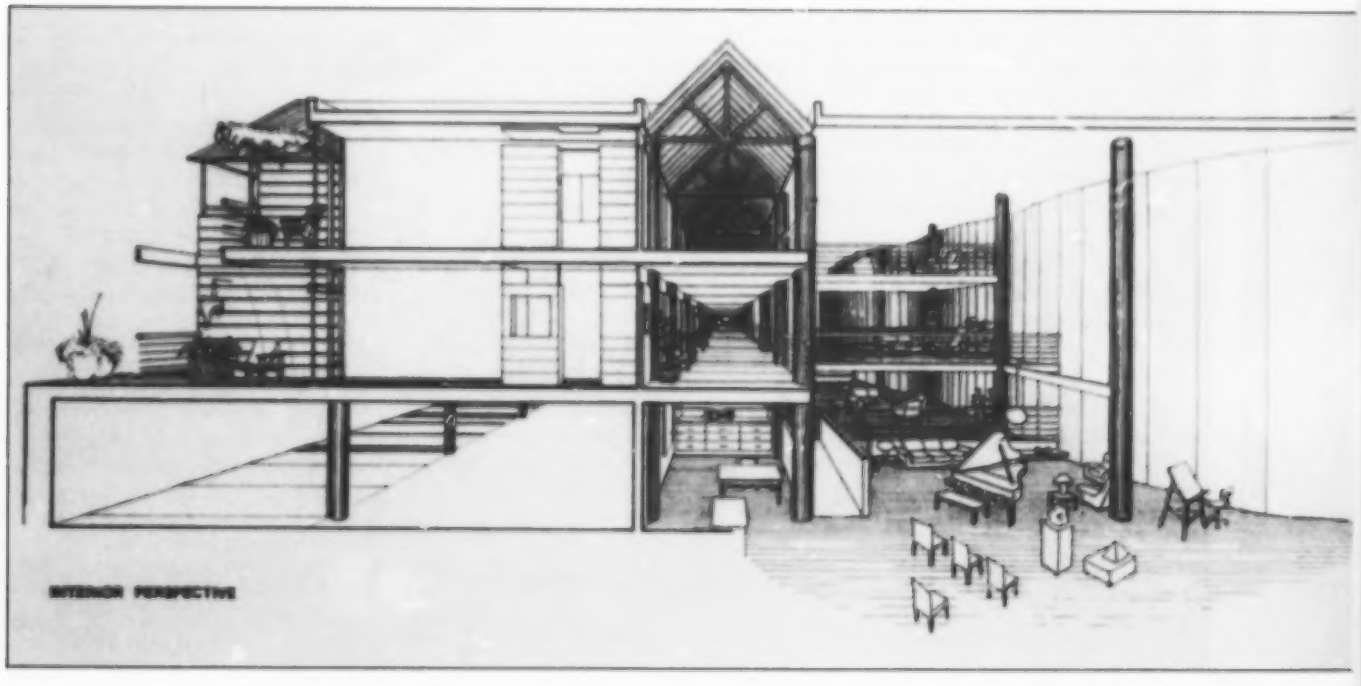
"Design for Aging"

A nationwide competition and an AoA-funded guide for architects

Architecture student Marta Perlas' award-winning design of a residence for the elderly in Holly Springs, Mississippi took into account Mrs. Levitsky's top prizes in the last three rose shows of the Garden Club, Miss Dora Corroll's quilting club, 90-year-old Mrs. Hilda Jones' passion for abstract painting, Dr. King's need for a quiet library to continue his historical writings, and the Barker sisters' 8-foot tall china cabinet from the 1600's.

The china closet could fit in with favorite sofas and chairs of other residents in the dining room or the lounge; the library is on the fourth floor; the quilting club could gather at one end of the lounge; the sixth floor offers a place for music and painting; and the garden runs the length of the building, offering plenty of room for Mrs. Levitsky to experiment with her roses or retired farmers to share their

Interior perspective of the award-winning design of a residence for the elderly by Marta Perlas, a student at the Southern California Institute for Architecture.



secrets for growing the fattest tomatoes.

Meeting the needs of these fictional residents of the real town of Holly Springs was one of the requirements for the "Design for Aging" competition, organized by the American Institute of Architecture Students and funded by the National Endowment for the Arts and the American Association of Retired Persons. There were 79 entries submitted by 192 students (group designs were permitted) from schools of design and architecture throughout the county, and all the contestants had to read brief descriptions of the lives of 94 fictional elderly residents living in Holly Springs, population 7,500.

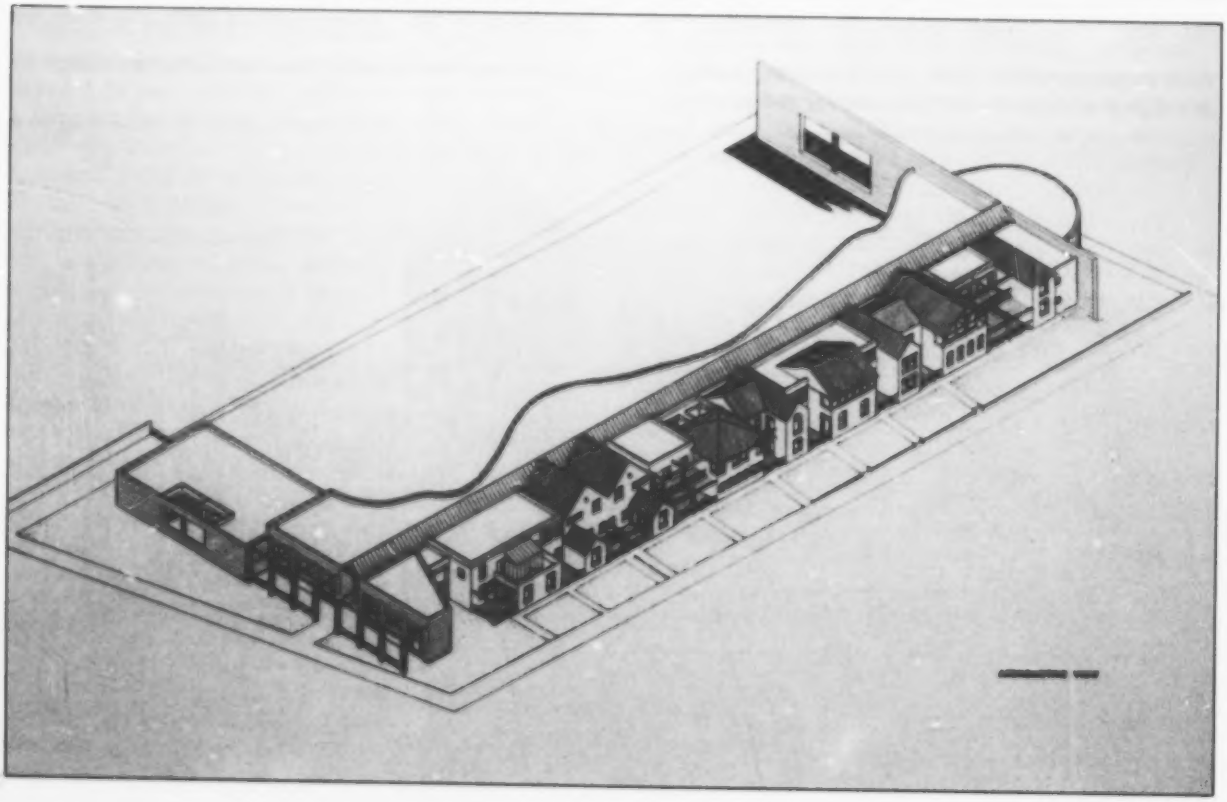
After digesting these colorful histories—Mrs. Barnes, a 1920's torch singer from Harlem who was later active in civil rights; Mrs. McCulloch, a beautician who operated the Palace of Beauty on the square for over 40 years; and the aristocratic Miss Beech who started a library in the black community in the 50's—students were left with little doubt that the elderly, as the competition guide noted, "cannot be easily categorized or generalized about—they are as complicated as any client can be."

The competition guide's detailed description of Holly Springs came complete with a history of the town, photos of antebellum homes and the all-important town square, an analysis of why the townspeople are so neighborly, and a discussion of the way the town's trees horizontally define public space.

Considering the diversity of the elderly residents of Holly Springs was not the only requirement for contestants. They were also asked to use as a resource *Design for Aging: An Architect's Guide*, a new book prepared by the American Institute of Architects (AIA) with support from the Administration on Aging and printed with funds from the National Endowment for the Arts. Over 2,000 free copies of the *Guide* were distributed by the Administration on Aging, the National Endowment for the Arts, the Department of Housing and Urban Development, the Department of Agriculture's Farmer's Home Administration to agencies and organizations within their constituencies. Copies of the *Guide* may now be obtained for $40 ($28 for AIA members) from: AIA Fulfillment Services, P.O. Box 753, Waldorf, Md. 20601.

The design submitted by Marta Perlas, who attends the Southern Cal-

Ms. Perlas' design from another perspective



ifornia Institute for Architecture, was one of five award-winning designs selected by experts in the field of architecture and gerontology. The designs—which reflect a range of housing options that help the elderly to sustain their independence in the community—have been published in a *Design for Aging Competition Catalog* which is available for $7.00 from: AIAS, 1735 New York Ave., N.W., Washington, D.C. 20006

Excerpts from an Explanation of the Design

"... With my design, I have attempted to create an environment that resembles a small town as much as possible.... The corridor that gives access to the apartments becomes a street, with living units on one side and common activity areas on the other. This arrangement allows residents to choose from a wide array of privacy levels, ranging from the heart of their homes to group activity spaces and the garden, passing through a series of intermediate terraces/balconies and small lounges where semi-private gatherings can take place.

Meals, housekeeping and nursing care are offered but not mandatory. In this way, residents can continue to be self-sufficient as long as possible, knowing that the support is there whenever needed.

This is one of the reasons to include the infirmary in the program as one element of support. It enables companions to live in the same community, even though one may require intensive care while the other may be able to lead a normal life ...

Number of Residents

I decided to provide housekeeping facilities for 50 residents because a larger group in a town of 7,500 inhabitants would probably result in segregation of the elderly from the rest of the population. It is better to provide several complexes spread out in the town than having one large facility for the following reason: senior citizens would not have to leave their old neighborhood, family and friends but merely move into a more comfortable and appropriate living arrangement in the same area.

Site and Living Units

... (I chose the) site because of proximity to the town square, which is so relevant in Holly Springs' social life and is the main center of commercial activity....

Purposely avoiding the institutional approach of cell-like units, I have given each unit an individualized exterior.... The single one-bedroom units were designed for the many elderly who live alone and who do not desire or are not physically able to do housekeeping or cooking chores.... The double one-bedroom units are especially for couples.... The double two-bedroom apartments serve those who want to live with companions but also prefer a private space for themselves.

At the north end of the street corridor is the auditorium which also serves as a movie theatre and chapel, as well as an assembly/lecture hall.

There are five levels—on each a different activity. On the first is a coffee shop where residents can have coffee, tea, soda and snacks at almost any time.... On the next level is the dining room. This could include some of the tenants' own furniture which, carrying a strong sentimental value, would make them feel more at home.

The same idea of using some of the residents favorite chairs and sofas is carried out for the main lounge on the next level. In addition, several seating arrangements permit different activities to go on at the same time. For example, the quilt club could gather while others enjoy the fireplace or the garden view.

The (next) level houses the library, which offers an alternative to those people who cannot go to the town's library every day and could provide volunteer work for those tenants who so desire. Finally, on the last level, there is a space for music, arts and crafts, where residents can practice various activities like painting, sculpting, playing an instrument, or even exercising in a group.

The Garden

An undulating glass wall separates the recreational areas from the garden. Along that wall, there is a continuous chain of flowering trees such as the Japanese cherry blossom, silk trees, orchid trees ... flowering dogwood and magnolia that would change with the passing of the seasons.... The rest of the garden is an open space that resembles an open prairie or meadow, offering a place of relaxation and recreation.

Elderly Parents of the Developmentally Disabled:

Shouldering Some of Their Burden

by Mimi Whistle

Ernest's 103-year-old father and their house deep in the Ozark mountains.

Most of us push thoughts of our own death out of mind. But when they intrude more frequently as we get older, there is some comfort in believing that our children will be adults able to care for themselves.

There is no such comfort for elderly parents of adult children with developmental disabilities such as mental retardation, epilepsy, cerebral palsy or autism. When these parents become frail or die, who will provide their adult children with the daily care they need? Probably no one unless it's the staff members of an institution. These parents not only avoid the thought of their own death. They avoid sad and frightening worries about what will happen to their children.

Life Care Planning

To ease some of these anxieties, the East Arkansas Area Agency on Aging and Focus, Inc. in Jonesboro, Arkansas have established a Life Care Planning Program (LCPP) for Rural Elderly Parents of Adult Developmentally Disabled Children. Focus, Inc. is a nonprofit agency that has served primarily developmentally disabled children, but as a result of the project, is expanding its area of concern to include older disabled individuals.

Funded jointly by the Administration on Aging and the Administration on Developmental Disabilities, the project is seeking out parents aged 60 and over who have developmentally disabled adult dependents and is identifying existing public and private services to assist them. The project staff receives valuable guidance from a Board of Directors, which includes a broker, attorney, psychologist, general practitioner who formerly directed a nursing home, and a counselor who assists families with developmentally disabled members. A special Legal and Financial Task Force advises the staff on life care planning options for specific families.

The project is also training staff from agencies serving the elderly and agencies assisting the developmentally disabled to recognize common concerns and to work together in solving problems affecting their clients. In addition, the project is developing parent training materials as well as a model estate planning guide for nationwide distribution.

Identifying families in need of assistance is not an easy task since the project is serving 17 counties in east and north central Arkansas—most of them areas with small towns and farming communities. At this point, there is no clear picture of the total number of families with developmentally disabled adult children. It is interesting to note, however, that in the first two months of the project, case managers and nurses from the East Arkansas Area Agency on Aging were able to identify 60 such families. Since then, project staff have identi-

Mimi Whistle is Co-Coordinator of the Life Care Planning Project for the East Arkansas Area Agency on Aging in Jonesboro, Arkansas.

Ernest on the front porch.

fied 140 additional families, with information from three counties still to be compiled.

Preliminary information from many of these families indicates severe economic and medical need, a reluctance to consult physicians and attorneys, and a profound anxiety in both elderly parents and disabled adult children about the future. These difficulties are compounded in Arkansas by physical isolation, inadequate transportation, and a pride in self-reliance that keeps residents from making use of available services.

No matter how great the hardships, the well educated and reasonably prosperous parents are in a much better position than the poorer and less educated ones when it comes to planning for their dependents. The lower-income parents are very aware that they cannot afford the services of an attorney. Unfortunately, geographic isolation and lack of education also make them less likely to become aware of the services of the Life Care Planning Project.

Ernest and His Father

Given limited resources and staff, one of the project's chief problems has been reaching isolated families in the extensive geographic area served. In some instances, families are extremely isolated as the case of "Ernest" illustrates. An employee of the East Arkansas Area Agency on Aging brought Ernest and his father to our attention.

"How old is Ernest?" was the first question I asked.

"Seventy-two," she responded.

"And the father?"

"One hundred and three."

Ernest's neighbors call him "simple." Case managers who work with people like Ernest classify him as "mildly retarded." Ernest says, "I'm a little slow."

Independence County, where Ernest and his father live, is Ozark mountain country. To reach Ernest's house, you turn off State Highway 60 and take a black-top road 10 miles out and a little up. Then it's gravel, 8 miles of it, and watch close for the turn-in. Two hundred yards brings you to a set of sheds and the 2-bedroom frame house, once whitewashed, now weathered gray, that Ernest's daddy built 45 years ago.

Ernest's father is suffering from severe arthritis, poor vision, hearing loss, and cancer. Today, he is unable to care for himself and son the way he always had. Ernest's father never expected this. He believed, because of Ernest's "condition," Ernest would "go first." It now appears that he will be wrong.

Ernest no longer plows or hoes, as he did when he was younger. Just as important, his father can no longer supervise work done outside the house. A large pile of firewood stands on one side of the porch. "Did you chop that yourself?" I asked. "Nope, have to hire it done."

When I inquired how he spent his day, he said he didn't do much. "Work a little bit in the house, not much."

I asked, "Do you have a T.V., and do you like to watch it?" He answered, "Not much, try to get the news though."

Ernest cooks for himself and his daddy now, and when the dishes need "doin' " he washes them in the rain barrel that stands out front. He helps his father get in and out of bed, and "brings him things." Mainly, he keeps his daddy company.

He says he's happy and you can see it. He smiles often, laughs easily, and is quick to tease. But he admits "it's awful lonesome up here." He likes visitors and tells us "come again." He says it again, and also when we leave.

Ernest says his mama "left 14 years back, I just take care of him. He ain't got long."

"Will you live here then," I asked? "Reckon not," he said, "guess I'll go to a nursin' home. Yeah, everybody else does. Some of them pretty good, some of them awful bad. Some of them awful bad. I don't want to go until I have to. Most everybody have to. I'll stay here long as I can."

Ernest may be able to stay at home after his father dies, possibly with help and training in basic living skills from the Area Agency on Aging caseworker who has already been visiting his father. The telephone reassurance program, funded by United Way, may also help by calling Ernest daily to check on his health or just to chat. But the solution will depend on what Ernest wants. Since he likes people, he may prefer to go to a nursing home rather than live in the woods, alone. Whatever his decision, the Life Care Planning Program staff will be ready to help.

For further information about the Life Care Planning Project and project materials, contact: Mimi Whistle, East Arkansas Area Agency on Aging, P.O. Box 5035, Jonesboro, Ark. 72403-5035 (501) 972-5980 or Louisa Richards, Focus, Inc. (501) 935-2750.

Dental Program In Central Texas Wins AoA Health Award

"Losing your teeth is not an inevitable consequence of aging. It's caused by an insidious gum disease that can be prevented and successfully treated."

This opening statement to a recent *Washington Post* article on gum disease or periodontitis would find ready agreement among the staff of the Central Texas Dental Health Program which has provided oral health education to 4,300 senior citizens in a 7-county area since 1982.

The Texas seniors who have participated in the program know about periodontitis, a bacterial infection under the gums that causes loss of bone, affects 9 out of 10 adult Americans, and accounts for 70 percent of teeth lost after age 40.

They have learned that preventing or retarding the disease requires a 2-part daily regimen: brushing with a soft tooth brush up under the edge of the gums as well as on the surface of the teeth; and daily flossing between the teeth and under the gum to disrupt the colony of bacteria. The dental hygienists who conduct the program also stress that if gum disease has progressed, treatment by a periodontist coupled with aggressive home care, is required to stem bone loss and save teeth.

For its success in providing vitally important dental education to senior citizens, the Central Texas Dental Health Program was the recipient of an AoA Project Health Award during Older Americans Month ceremonies this year. The program, which has also developed basic dental care services for low-income seniors in Bell County, Texas, is the result of an effective partnership of the State Department of Health, an Area Agency on Aging, and local dentists who volunteer their services.

Dental hygienists from the Division of Dental Health Services (Region 6) of the Texas Department of Health visit senior centers during the summer months in the 7-county region to present the dental health program. It includes a discussion of diet and dental health, oral hygiene instruction, distribution of natural and denture toothbrushes and denture cleaning for some participants. The Central Texas Council of Governments Area Agency on Aging schedules the programs at various senior centers and pays for dental materials.

Oral health screening was added to the program in 1984, with 9 dentists volunteering to screen 55 seniors the first summer, and 14 dentists screening 114 people in 1985. Many of the seniors were receiving their only oral health assessment.

The dental hygienists cover a different topic each summer. The educational materials used in the presentations are: "Oral Cancer Self-Exam," a pamphlet available from the American Cancer Society, P.O. Box 4900, Austin, Tex. 78765; two pamphlets, "Diet and Dental Health" and "Keeping Your Smile in the Later Years," and a film or videotape, "Options for Health in Later Years," available from the American Dental Association, Marketing Services Dept., 211 E. Chicago Ave., Chicago, Ill. 60611; and a slide show, "Care of Natural Teeth and Gums," available from the Texas Department of Health, Bureau of Dental Health, 1100 West 49th St., Austin, Tex. 78756.

Oral health instruction and denture cleaning by the dental hygienists and oral screening for cancer by volunteer dentists are also provided at local health fairs initiated by the Area Agency on Aging during Older Americans Month in May.

In developing the basic dental care program for indigent seniors in Bell County in 1985, the Area Agency on Aging and the Department of Health were joined by the Central Texas Dental Society. Senior centers identify members needing care and arrange transportation, while the AAA-funded Information and Referral Center in Temple, Texas determines financial eligibility and refers seniors to dentists participating in the program. The dentists donate their services and receive limited reimbursement for materials.

For further information about the Central Texas Dental Health Program, contact: Margareta A. Williams, Director, Central Texas Area Agency on Aging, P.O. Box 729, Belton, Texas 76513 (817) 939-1886.

Oral screening at the Highrise Senior Center.

Young Adults On Probation Do Chore Work for Elderly

Young adults, mainly first-time offenders, who are on probation and required to do community service work are proving to be effective chore workers for the elderly in Port Lavaca, Texas.

Referred by the County Probation Office and supervised by the Calhoun County Senior Citizens Association in Port Lavaca, the young people are assigned to mow lawns, clean flower beds, wash windows, move furniture and do other jobs that are vital to the running of a household. This type of handyman assistance is hard to come by in most communities, even when the elderly are willing to pay the going hourly rate.

Arrested for such crimes as driving while intoxicated, possession of marijuana and shoplifting, the young adults are required to perform 80 to 150 or more hours of community service in order to complete their sentences. Most of the probationers used by the Senior Citizens Association are in their late teens or early 20's.

"We have never had any problems with the probationers. Most of them are well mannered and good workers," says Mrs. Fannie Griffith, executive director of the Senior Citizens Association, which operates a multipurpose senior center. She adds, however, that "as a rule, we use the youth in the center before we send them out into the community to get an idea of their personalities and work ability."

The staff calls the elderly person to schedule a time for the young adults to work and to request that the person call the center back to report the number of hours of service performed.

"The elderly and the youth seem to really enjoy each other," comments Mrs. Griffith. "Most of our senior citizens furnish the kids with plenty of cookies and drinks while they work. They enjoy the chance to 'mother' the kids." Mrs. Griffith notes that several senior citizens associations in the Southwest Texas region also use probationers as chore workers.

According to David Nicholson from the County Probation Office, who approached Mrs. Griffith with the idea for the program, "it keeps the kids off the street and hopefully out of more trouble."

For further information, contact: Fannie Griffith, Director, Calhoun County Senior Citizens Association, 234 East Main, Port Lavaca, Tex. 77979 (512) 552-3350.

M.D.'s and Dentists Visit Day Care Centers And Nursing Homes

Community-service-minded doctors, dentists and optometrists are making "house calls" to shut-ins and bringing care to the elderly in adult day care centers and nursing homes through a program organized by Associated Catholic Charities of New Orleans (ACC).

The idea for the Catholic Charities' "Homebound Program" was conceived in 1978 by Dr. James Briggs, a dentist who, at the time, was driving 80 miles between New Orleans and Baton Rouge to treat his grandmother who was housebound. Quoted in a winter issue of the *AARP News Bulletin*, Dr. Briggs said his grandmother "had called nearly 20 dentists to ask if they could come to her home," but found that none of them made home visits.

This experience led him to affiliate with Associated Catholic Charities and to recruit dentists in the New Orleans area to make house calls to private residences and to provide general dental screening in adult day care centers and nursing homes. The program was subsequently expanded to include internal medical specialists and optometrists.

There are currently 4 M.D.'s, 4 optometrists and 14 dentists on contract to the program, which generally takes about 1 day a week of their time. In addition to making house calls, they do general screenings and provide individual care, as needed, to patients in 25 to 30 nursing homes and 4 adult day care centers in greater New Orleans.

Medical and optometric procedures are often reimbursed by Medicare and Medicaid (no dental services), and equivalent fees are charged to patients not covered by these programs. But the remuneration for the professionals involved is still consid-

A dentist and a doctor visit patients for Catholic Charities' Homebound Program in New Orleans.

erably less than they receive in their private practices. High malpractice insurance for care provided in the home, especially for doctors, is another consideration—a factor that led the program staff to seek out doctors based in university hospitals that have comprehensive malpractice insurance.

A doctor associated with the program, Dr. Richard Campeau of Tulane University Hospital, reports that house calls by M.D.'s have been the least successful component of the program. He notes that while dentists can make plates and impressions relatively easily in private homes, house calls for M.D.'s are more complicated. "We rely on high technology equipment and you can't bring an X-ray or electrocardiogram machine to a private residence." Dr. Campeau works under Dr. William Lacorte, also of Tulane University Hospital, who is the chief physician for ACC's Homebound Program.

Campeau, who makes about four house calls a month, notes that it's not profitable or "efficient time-wise in terms of patient care" for most doctors to make house calls, and "if they are not community-service oriented, it's probably not going to be done." But Campeau thinks that a house call service would be practical in a high rise apartment for the elderly where a larger number of patients could be seen.

This is the case, he points out, in the adult day care centers that the Catholic Charities doctors serve in and around New Orleans. He says the doctors can bring along X-ray machines and other needed equipment and see enough day care clients to make it an efficient use of the doctors' time.

Campeau says this type of service for adult day care patients in the poorer areas of the city is needed because "probably 80% of them don't have a doctor. They may see a resident doctor at Charity Hospital, but it's probably a different doctor every time."

According to Campeau, the doctors in the Catholic Charities program working in nursing homes are also providing much needed individual care. "A nursing home may have three doctors on contract, basically because regulations require that all patients be seen and physically examined periodically . . . But these doctors are not necessarily devoted to geriatrics." He says doctors working with the Homebound Program do have a special concern for the elderly and "will follow up on the patient's lab reports," and, in general, provide more individual attention.

Staff at Catholic Charities handle calls from homebound individuals, adult day care centers and nursing homes, doing the necessary paperwork and referring callers to appropriate doctors and dentists who are on contract to the agency. The Homebound Program staff may also refer callers to other programs in the city, such as a "dental van" operated by the New Orleans Council on Aging that brings dental screening and other services to senior centers.

According to staff in the Homebound Program, roughly 35 similar programs have been established nationwide, many administered by Catholic Charities organizations and by Volunteers of America, in cities such as Philadelphia; Houston and Dallas; Portland, Ore.; and Atlantic City and Camden, N.J. Volunteers of America is a nonprofit social service agency, headquartered in New Orleans.

For further information about the Homebound Program, contact: Keith Horcasitas, Associated Catholic Charities of New Orleans, 1231 Prytania St., New Orleans, La. 70130 (504) 523-3755.

AoA Project To Use Retired Fla. Attorneys, Following New Ruling

Taking advantage of a recent Florida amendment allowing retired attorneys who are not members of the State Bar to provide free legal assistance, AoA funded two projects this summer to recruit and train retired lawyers to serve the elderly.

Funded through an $81,600 AoA grant to Florida's Office of Aging and Adult Services, the pilot projects will be developed by Area Agencies on Aging in Ft. Meyer and Tallahassee. The Tallahassee project will focus on three rural counties where legal services funded by the Older American Act are currently not available to senior citizens.

With help from the Florida Legal Services Corporation, the retired lawyers will be trained in issues affecting the elderly, such as the complexities of Medicare and Medicaid regulations, purchase of supplemental health insurance, or contract terms for entering life care communities.

The retired attorneys will not engage in litigation, but will provide counseling and education to seniors on a variety of legal matters—denial of Medicare reimbursement, faulty home improvements, consumer fraud, etc. Supervision for the attorneys and follow-up assistance for the clients will be provided by two practicing attorneys who will serve half-time as directors of the projects.

This kind of legal assistance from retired attorneys who are not members of the Florida Bar would not have been possible prior to adoption of the "Emeritus Attorney Amendment" by the Florida Supreme Court in the fall of 1986. Before passage of the Amendment, attorneys who had practiced in other states and retired to Florida were limited to paralegal status, as are all attorneys moving to Florida who have not passed the State Bar exam. Under the new ruling, lawyers retiring to Florida who have practiced for 10 of the preceding 15 years in another state can provide, under the supervision of a certified legal aid organization, free legal assistance primarily to low-income individuals.

The amendment, in effect, gives retired attorneys a limited license to practice law—including engaging in court proceedings—so long as they are offering free legal services. The retired attorneys must file appropriate documents with the Florida Supreme Court to receive approval to do *pro bono* work. Most legal services providers in the state have the forms needed for a retired attorney to qualify for the program.

Jerome Kaplan, a retired attorney and vice chairman of the State Legislative Committee of the AARP, sees the Emeritus Attorney Amendment as a "landmark case that opens up the thinking of the other states with similar bar requirements." Kaplan adds: "Through community service, I've been able to see that I'm not alone, that there are others interested in similar work. Though we've retired from our jobs, we haven't stopped wanting to continue service . . ."

Abby Walters, Older American Act Legal Services developer for the Office of Aging and Adult Services, is excited about the possibilities opened up by the amendment. "We see this as a unique opportunity to blend private and public resources to maximize assistance to seniors. Also, quite a few retired lawyers have expressed frustration at the limits of their practice rights . . . With the large number of retirees who migrate to Florida, we believe that there is a large pool of untapped ability."

Ms. Walters notes that the AARP, Area Agency on Aging staff, the American Bar Association and Title III legal service providers have been working together to organize a campaign to capitalize on the benefits of the new rule.

For further information about the AoA-funded projects, contact: Abby Walters, Legal Services Developer, Aging and Community Services, Florida Department of Health and Rehabilitative Services, 1317 Winewood Blvd., Tallahassee, Fla. 32301 (904) 488-2881. For information on the Emeritus Attorney Amendment, contact Michael Tartaglia, Director of Public Interest Programs, Florida Bar Association, Tallahassee, Fla. 32301-8226 (904) 222-5286.

Services and Shared Housing for Elderly Lithuanian Immigrants

In addition to the problems normally associated with old age, ethnic elderly often face an additional barrier capable of turning even a minor difficulty into a nasty aggravation.

That barrier, of course, is language.

Of the roughly one million Americans who identify themselves as being of Lithuanian ancestry, at least 20% are 60 or older. Of these, about 35,000-40,000 have little or no proficiency in English. Most of this group came to the U.S. around 1950 (or later) as adults at or near their middle age, took menial jobs and never managed to learn anything but the most rudimentary English. Today, as they are well into their 70's, 80's or even 90's, their inability to communicate adequately in English often hampers their dealings with private and public bureaucracies as well as their access to social services.

In 1981, the Lithuanian-American Community of the USA, the largest national organization of Lithuanians in America, established the Lithuanian Human Services Council (LHSC) to provide diverse support services to the Lithuanian-American elderly. Headquartered in Chicago (which has the largest Lithuanian community in the United States), LHSC maintains local chapters in Cleveland, New York, Los Angeles and St. Petersburg, and plans to extend into Boston, Detroit and Worcester, Mass. in the near future. (These seven cities contain nearly 70% of America's foreign-born Lithuanian population.)

Services offered by Lithuanian Human Service Council chapters include all or some of the following: information, referral, translation, interpretation, advocacy, transportation, escort, counseling, medical check-ups, and legal advice. The Chicago organization, which provides all of these services, has a nutrition and residential program as well.

In 1985, LHSC received a $50,000 grant through the Illinois Department on Aging to develop a shared-home project that would promote community-based ethnic services for Chicago's Lithuanian elderly. With generous support from the local business sector and the Lithuanian-American community at-large, LHSC was able to acquire a spacious building that not only houses its national offices but a senior center and the shared housing project as well.

The building, which is located in the city's main Lithuanian neighborhood, contains a senior center on the first floor and a 6-bedroom apartment for the elderly on the second. The senior center consists of a multi-purpose hall, a library/reading room and an arts and crafts gift shop. The hall is open for informal gatherings around a cup of coffee or game of cards as well as for more structured events: lectures, panel discussions, story readings, musical presentations, film screenings, etc. Since June, it has also been used as a dining room, serving full Lithuanian-style dinners five days a week to seniors, the disabled, and the unemployed at reduced prices (and at regular prices to everyone else). The Center's kitchen also prepares dishes for the LHSC Meals on Wheels program.

The congregate apartment on the second floor houses six seniors, each of whom has a private bedroom. There is one bathroom for every two residents, and the kitchen, dining room and large living room are shared by all six. The basic idea of this type of living arrangement is to provide a maximally satisfying environment for elderly people who are no longer able to live completely by themselves, yet are much too strong and healthy to be confined to a nursing home.

Since the current residents (three men and three women) are all over 75, they need and receive transportation to and from the doctor, hospital, pharmacy, and any other office or store, together with any necessary interpretation and advocacy assistance. They are also served by a homemaker who keeps house and cooks three meals per day six days a week. On the seventh day the residents prepare their own meals, a task which they are fully capable of performing on a once-a-week basis and an activity which they all share in and enjoy.

Since the residents are matched for compatibility, there is generally a high level of personal interaction. For example, residents take strolls together in nearby Marquette Park, or they sit around the table after dinner reminiscing about their youth in independent Lithuania. (Lithuania is a small country north of Poland which was occupied by the Soviets in 1940, the Nazis in 1941, and the Soviets again in 1944, events which forced nearly a seventh of the population to flee abroad.)

"We're like a family here," says one of the residents. "Better than a family," adds another. "My kids would never sit down and listen to me talk about all the things we can talk about here."

Such sentiments suggest that small-scale community based assisted living, administered by a respected community organization, seems to be one answer to the senior housing problem, especially for elderly with strong ethnic ties. The major challenge, of course, is how to "mass-produce" this concept so that thousands of seniors can be served. LHSC believes the strategy should be to utilize existing single- and two-family homes to provide an intimate congregate living environment to the aging and thereby also to maintain the stability and viability of ethnic neighborhoods.

For further information, contact Mykolus Drunga, Director of Communications, Lithuanian Human Services Council of the U.S.A. Inc., 2711 West 71st Street, Chicago, Ill. 60629 (312) 476-2655.

This article was written by Mykolus Drunga.

RESPITE—Helping Caregivers Keep Elderly Relatives at Home—Guidelines for a Program Whose Time Is Now. By Peggy Eastman and Annette Kane. National Council of Catholic Woman, 1312 Massachusetts Ave., N.W., Washington, D.C. 20005. (202) 638-5050. 64 pp. $8 plus $2 postage and handling.

RESPITE — Helping Caregivers Keep Elderly Relatives at Home describes the National Council of Catholic Woman's (NCCW) experience in organizing respite services in 1900 parishes over the past four years and offers guidelines for other groups interested in developing similar programs.

The NCCW program began in December 1982 when 22 women representing six parishes in the Washington Archdiocese offered their services as respite volunteers. By 1986, the program had spread to 65 dioceses and involved over 4,000 volunteers.

The manual includes guidelines for organizing a respite program, an outline of the training sessions for volunteers, tips for recruiting and keeping volunteers, and ideas for funding.

How-To Manual On Providing Respite Care for Family Caregivers. Department of Health & Human Services. Available from: Project SHARE, P.O. Box 2309, Rockville, MD 20852. (301) 231-9539. $15 including postage and handling.

The *How-To Manual on Providing Respite Care For Family Caregivers* defines respite care and discusses the major steps in developing local respite care programs—including funding, recruiting, training, scheduling, and evaluation. It explains how volunteers can play special roles in all phases of the program.

In preparing the Manual, staff from Project SHARE, which is a clearinghouse for information on improving the management of social services, talked with coordinators of local respite care programs across the country. The staff also selected helpful instructions from publications on respite care found in the clearinghouse collection.

At the end of the manual, there is a bibliography of publications on respite care and a listing of resource organizations which can provide additional information.

A Guide to Compassionate Care of the Aging. By John Gillies. 1985, 225 pp. Thomas Nelson Publishers, P. O. Box 141000, Nashville, Tenn. 37214. 800-251-4000. $7.95.

The author, John Gillies, says: "This book is about the many ways people with good will, compassion, and imagination have found to make life more livable and worth living for older friends."

Based on his own personal experience as a caregiver and his professional work with the elderly, Gillies offers guidelines for community task forces and committees to use in coordinating and planning services to help the elderly maintain their independence. Using the basic emotional, physical and practical needs of older Americans as a framework for the book, Gillies then describes numerous programs across the country that have proven to be effective in meeting these needs.

The author and his wife know a great deal about the needs of the elderly, having experienced 10 years of caring for her mother, who was a victim of Alzheimer's, and her father, who was paralyzed and aphasic from a stroke. Their experiences of the entire spectrum of caregiving—from home care and supervised care to nursing home care—are described in a previous book, *A Guide to Caring For and Coping With Aging Parents*, also published by Thomas Nelson.

This new book, *A Guide To Compassionate Care of the Aging*, was written after a 2-year study, which involved researching gerontological journals and interviewing dozens of professionals and experienced volunteers. According to Merle E. Springer, Executive Deputy Commissioner of the Texas Department of Human Resources, Mr. Gillies' book is "an excellent guide which will enable individuals, community groups, churches, and the aging to find practical ways to improve or maintain a quality of life with dignity and respect . . ."

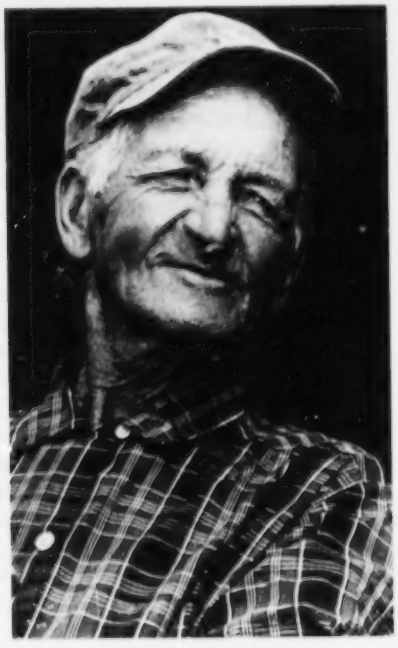
Wilbur J. Cohen, a former Secretary of the U.S. Department of Health, Education and Welfare, says the book is "simply and clearly written . . . one of the most helpful books on aiding older people."

The Aged In Rural America. By John A Krout. 1986. 182 pp. Greenwood Press, 88 Post Road West, Box 5007, Westport, CT 06881. (205) 226-3571. $29.95

In an earlier book on the rural elderly, John A. Krout stated that the "existing literature on the rural elderly should be assessed and integrated before more research on this topic is undertaken." He says that

The Aged in Rural America represents one attempt at such an assessment and integration.

In this recent study, Krout explores the fundamental sociological questions concerning the demographic, socioeconomic, and cultural characteristics of the rural elderly versus their urban counterparts. The author maintains that the needs of the rural elderly are not being adequately met by current programs and examines some of the reasons why. He discusses the availability, acceptability, and accessibility of formal services, as well as policy and program issues as they relate to this population group.



The Aged In Rural America covers demographic characteristics; economic status; work, retirement, and leisure; physical health; mental health; housing and transportation; informal support (family, friends, and neighbors); and formal services and service provision. Each chapter includes a review of the literature on the status of the rural elderly with respect to the topic addressed, the degree and nature of rural/urban differences, and any changes that may have occurred in these differences over time. Also, each chapter has a section on the issues and problems that future research should address, a chapter summary, and references.

John A. Krout is Associate Professor of Sociology and Director of Sponsored Research at SUNY, Fredonia.

Coordinated Service Delivery Systems for the Elderly: New Approaches for Care & Referral in New York State. Edited by: Ruth Bennett, Ph.D., Susana Frisch, MA., Barry Gurland, MD, David Wilder, Ph.D., all of the Center for Geriatrics and Gerontology, Columbia University, New York. 1984. 198 pp. The Haworth Press, Inc., 28 East 22 St., New York, NY 10010. (212) 228-2800. $28.95 plus $2 shipping.

The Columbia University Center for Geriatrics and Gerontology convened a conference, co-sponsored by 8 other New York State organizations, in October 1981 to examine a broad array of issues and problems relating to the development of community-based coordinated systems for the delivery of long-term care. *Coordinated Services Delivery Systems for the Elderly: New Approaches for Care and Referral in New York State* contains the presentations made during the conference as well as discussions and concluding remarks and recommended readings on long-term care.

This book provides information on the management of innovative service delivery systems, focusing on health and medical care, transportation, nutritional services, home care, senior centers, and the role of the long-term care institution. Papers in the volume include descriptions of coordinated service delivery programs in Albany, Buffalo, New York City, Troy, and Rochester.

The Hurt That Does Not Show. 6-booklet set. Self Help for Hard of Hearing People, 7800 Wisconsin Ave., Bethesda, MD 20814. (301) 657-2248. $3.00 per set.

The six-booklet set is a part of a national outreach project on hearing problems that has included three programs on public television—the final program on "Noise: The Invisible Risk," scheduled to be aired May 13. The following booklets, underwritten by the Grace Foundation, as supplements to the public television series, are intended to provide basic information on understanding hearing loss, communication for the hearing impaired, and the dangers of noise:

To Hear: Resource Guide lists information centers, clearinghouses and organizations equipped to answer a wide range of general and specific questions and to offer diagnosis, assistance and information on hearing loss.

Hearing and Self-Image discusses how to meet the challenge of hearing loss and coping with the mental pain, pitfalls, stereotypes, and stigma. This booklet also gives examples of accomplishments of hearing-impaired people.

Communication Tools describes how new devices, technology and skills can help the hearing impaired get the most out of life, including medical options, types of hearing aids, new systems being developed, speechreading hints, sign language, and other devices and means to an independent life.

Noise: The Invisible Risk explains how continual noise exposure can result in irreversible damage to your hearing and general health. The brochure discusses how the ear works; the toll noise takes, especially in our

modern culture; how to protect yourself from noise; and how to help control noise in your community.

Hearing and the Child explains how normal speech develops; causes of childhood hearing loss; warning signs of hearing problems; diagnosis and treatment; and signing vs. oral communication.

The Aging Ear states that by age 75, 3 in 10 of us will suffer significant hearing loss. This booklet includes: causes of adult hearing loss; special problems facing the elderly; when to suspect a hearing loss; how to get help; getting the most from a hearing aid; and communication tips.

Handbook of Gerontological Services. Edited by Abraham Monk, Ph.D. 1985. 627 pp. Van Nostrand Reinhold Co., Inc., 115 Fifth Avenue, New York, N.Y. 10003. (212) 254-3232. $38

The editor of this comprehensive guide is Dr. Abraham Monk, Brookdale Professor of Gerontology at the Columbia University School of Social Work, and director of both the Brookdale Institute on Aging and Adult Human Development and the Long-Term Care Gerontology Center of Columbia University's Faculty of Medicine.

In his preface, Dr. Monk states: "*The Handbook of Gerontological Service* aims to meet the need for a comprehensive review of the types of social intervention methods and the range of services available to the elderly. The *Handbook's* primary concerns are the issues that service providers confront on a day-to-day basis, from the time a particular program is planned and developed until it comes into contact with its intended beneficiaries."

The book is addressed to a wide audience of service staff, informal caregivers, policy makers, administrators, researchers and the elderly, with special relevance for practitioners who staff multidisciplinary teams in hospitals, long-term care centers, multipurpose senior centers, mental health clinics, family service agencies and Area Agencies on Aging.

Policy, planning, and operation, the intricacies of public funding, contracting and monitoring the provision of services, as well as the increasingly important role of information processing in program management, are some of the subjects covered.

The *Handbook* is divided into seven parts: "Concepts and Issues," "Client Evaluation," "Treatment and Intervention Modalities," "Community-Based Services," "Home-Based Services," "Long-Term Care and Institution-Based Services," and "Policy, Planning, and Operation of Services." The contributors focus on the family domain, work and retirement, outpatient mental-health services, bereavement counseling, assistance to crime and abuse victims, legal advice, senior centers, living arrangements and residences, the chronically ill and incapacitated, respite and adult day-care programs, advocacy services for nursing-home residents, and protective legal and social services.

In the preface, Dr. Monk describes the 30 authors as experts who wrote from the vantage point of their day-to-day responsibilities. He said, "Some are front liners, the direct providers of the services they write about. Others are planners and administrators but still linked in a direct capacity with their assigned topics. Others are academic researchers . . . deeply invested in their specialities. Some have written with almost exclusive reference to the setting where they carry out their practice. Others have adopted instead a comparative perspective that includes several settings."

How Alone Is Alone?

by Donald G. Fowles*

It is often assumed that older people who live alone in the community face an increased risk of institutionalization or even death because they do not have the immediate emotional and physical support of a spouse or other family members in the household. Although this may be true for some, a new study from the National Center for Health Statistics (NCHS) indicates that older people who live alone are at least as healthy as other elderly residents in the community and that they enjoy frequent contacts with family members, friends, and neighbors.

The author of the study, Dr. Mary Grace Kovar, believes that any surprise we may feel about these findings should be tempered by the realization that these are "people who have, so far, successfully survived living alone in the community. Were they badly disabled, many might already have moved in with family or into institutions. They are, in a sense, a select group of people."

The study, based on a nationwide survey of noninstitutionalized older people in 1984, found that there were 8.0 million people 65 years or older who were living alone. They represented about one-third (30 percent) of the 26.3 million people in this age group who lived in the community.

In terms of their general demographic characteristics, older people living alone were quite different from their counterparts who lived with others. For example, most (80 percent) of the older people living alone were women, compared to only half (50 percent) of those who lived with spouses or others. About three-fourths (77 percent) of those who lived alone were widowed, whereas a similar percentage (79 percent) of those who did not live alone were married. The live-alones also tended to be older than those living with others; half (50 percent) of the former were at least 75 years old compared to only one-third (33 percent) of the latter.

This profile of older people who live alone is shaped by the fact that women tend to live longer than men. Also, women tend to marry men who are older than themselves, thereby increasing their chances of becoming widowed.

Contacts With Children and Others

Most older people who live alone have children and see them frequently. About 71 percent had one or more living children, including 19 percent with one child and 52 percent with 2 or more. In addition, 72 percent had living brothers or sisters. Only 11 percent of the live-alones had neither living children nor siblings.

About one-quarter (23 percent) of those who had living children saw one or more of their children daily, almost two-thirds (64 percent) saw a child at least once a week, and four of every five (80 percent) saw a child at least once a month. Furthermore, a high proportion (72 percent) reported that one or more of their children could arrive at their home within minutes if needed, and most of the rest said a child could be there within 3 hours.

Although mail was seldom used by older live-alones and their children to keep in touch, about three-fourths (78 percent) of those with children talked with one or more of their children at least monthly, including a third (36 percent) who talked with a child daily. Only 9 percent talked with children less than once a month.

Combining personal visits and telephone calls, the study shows that nearly all (91 percent) of older live-alones with children and a majority (64 percent) of all older live-alones

had at least monthly contact with children. The percentages for those with at least weekly contact were nearly as high (81 and 56 percent, respectively).

In addition to questions about the frequency of contact with children, the older live-alones were asked whether they had talked to or gotten together with any relatives or any of their friends or neighbors in the two weeks prior to the survey. The results of these questions show a very high level of social contact. For example, 90 percent of the live-alones had talked to either a relative or a friend or neighbor; 75 percent had talked to both. Likewise, 88 percent had gotten together with either a relative or a friend or neighbor; 53 percent had gotten together with both. Only 5 percent of the live-alones had not had any contact in person or by telephone with relatives or friends.

About half (51 percent) of the live-alones reported attendance at church or temple during the same 2-week period. About one-fourth (27 percent) had attended a movie, sports event, club meeting, class, or other group event.

Health

The NCHS survey found that the health of older people living alone was as good, on average, as the health of other older people in the community. For example, the survey respondents were asked to rate their health on a 5-point scale from excellent to poor. Most (70 percent) rated their health as good, very good, or excellent; 20 percent said their health was fair; and only 10 percent perceived their health as poor.

In response to another set of questions, 60 percent said they were not limited in their activities because of chronic health conditions. About one in six (17 percent) were limited in some way but not in their "usual" activity. Another one in six (16 percent) were limited in the amount or kind of usual activity, and one in 12 (8 percent) were unable to perform their usual activity. [Note: For people under the age of 70, "usual" activity is either keeping house, working, or, if neither applies, the ability to work. For people 70 or older, the concept of usual activity refers to the ability to perform a variety of personal daily activities (e.g., bathing, eating, dressing) and a variety of routine activities (e.g., household chores, shopping, financial transactions) without the assistance of another person. People over 70 requiring assistance with their personal daily activities are referred to as "unable to perform usual activity," and those requiring assistance in routine activities only are referred to as "limited in the amount or kind of usual activity."]

A majority (62 percent) of the live-alones had not spent an entire day in bed during the previous year. Only 24 percent had spent 7 or more days in bed.

The survey respondents were asked if there were a relative, friend, or neighbor who would take care of them for a period of time, if such care became necessary. The majority of the live-alones reported that someone was available to provide such care. About two-thirds (69 percent) said a relative could provide care for a few days. Another 17 percent said a friend or neighbor could provide such care, and only 14 percent said no one was available for that amount of time. Even if the care were needed for a few weeks, most live-alones felt that care would be available. Again, two-thirds (67 percent) believed family members would be available. About 10 percent could rely on nonrelatives, and 24 percent said no one was available for such an extended period of care.

Summary

The information above, as well as other data in the NCHS report, present a generally positive picture of the extent of family and social contacts and the health status of older people who live alone in the community. One explanation is that people who are unable to maintain their independence have already moved in with relatives or into institutions. Dr. Kovar also notes that there is some evidence that high levels of social contact and support have a positive impact on health and mortality.

Although most of the older live-alones in this survey appeared to be in good health and were active socially, there were some who were in poor health or who had very little contact with relatives or nonrelatives. These individuals should be of considerable interest to the community support system.

Source of Data

The data in the NCHS report came from the Supplement on Aging to the 1984 National Health Interview Survey (NHIS). The NHIS is an ongoing survey of over 40,000 households annually in the United States and is conducted by the U.S. Bureau of the Census for NCHS, a component of the Public Health Service, U.S. Department of Health and Human Services. The Supplement on Aging was administered to all household members 65 years or older and a half sample of those 55 to 64 years of age.

The data in this report are preliminary because only interviews from the first half of the year were included and because the data had not yet been edited. NCHS plans to release comparable data from the edited, full-year sample in the near future. NCHS will also release a public-use computer tape so that researchers may perform their own analyses of the full sample.

The report, *Aging in the Eighties, Age 65 and Over and Living Alone, Contacts With Family, Friends, and Neighbors,* can be obtained without charge by writing to: National Center for Health Statistics, 3700 East-West Highway, Hyattsville, Maryland 20782.

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* *Mr. Fowles is a statistician with the Administration on Aging.*

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